DEP.Nov. 29. 2011 H. 8:59AM AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDIC) SERVICES

No. 7203 PRIP. 4): 11/15/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
	/-		A. BUI		NG	R	
		445141	B. WIN	4G _		11/1	0/2011
	ROVIDER OR SUPPLIER Y HEALTH CARE & R	REHAB		2	REET ADDRESS, CITY, STATE, ZIP CODE 2910 PEERLESS RD CLEVELAND, TN 37312		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PRÉF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENT	rs	{F 0	00}		270	
	and Rehab on Nove acceptance of an A remove the Immedi F280, F323, F490 a the corrective action 8, 2011, removed the noncompliance con "E" level, F280 "E" I	eleted at Bradley Health Care ember 10, 2011, following llegation of Compliance to ate Jeopardy for F225, F250, and F520. The revisit revealed as implemented on November he Immediate Jeopardy but tinues at F225 "D" level, F250 level, F323 "E" level, F490 "E" evel, as evidenced by the					
	addressed on the A remain outstanding, submit a plan of cor deficiencies includir	oreviously cited and not allegation of Compliance. The facility is required to rection for all outstanding and the Immediate Jeopardy and scope.					55
	483.13(a) RIGHT TO PHYSICAL RESTRA		{F 2	21}			
	physical restraints in	e right to be free from any mposed for purposes of ience, and not required to nedical symptoms.			16		
	by: Based on medical nand interview the fac pre-restraint assessi	T is not met as evidenced ecord review, observation, cility failed to complete a ment and a physical restraint nt for one resident (#3) of reviewed.					
		PRISUPPLIER REPRESENTATIVE'S SIGN	ATURE /	40.	TITLE /1/18/	<u> </u>	X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDIC D SERVICES

No. 7203 PRIP. 5: 11/15/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDII	TIPLE CONSTRUCTION NG	COMPL	(X3) DATE SURVEY COMPLETED	
		445141	B. WING			10/2011	
	PROVIDER OR SUPPLIER Y HEALTH CARE & F	REHAB		REET ADDRESS, CITY, STATE, 2910 PEERLESS RD CLEVELAND, TN 37312	ZIP ÇODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED T DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
{F 221}	The findings included Resident #3 was as as 10, 2007, with diage Brain Injury, and See Medical record revision of the program Intervention and the mittens on at all times" Medical record revision of Care dated July 1non-compliance of the program Intervention of Care dated July 1non-compliance of the program Intervention of Care dated July 1non-compliance of the program Intervention of Care dated July 1non-compliance of the program Intervention of Care dated July 1non-compliance of the program Intervention of Care dated July 1non-compliance of the program Intervention of Care dated July 1non-compliance of the program of	dmitted to the facility on July noses including Paraplegia, eizure Disorder. ew of the Minimum Data Set ember 23, 2011, revealed the dependent for transfers, assistance with all activities of ident for decision making, and ins occurred four to six days a lew of the Falls Prevention ons dated March 10, 2010, and 12, 2011, revealed "hand les" ew of the Interdisciplinary Plan 5, 2011, revealed, with Gastric Tube (G-Tube) tube)pulling G-Tube out love restraint devices daily" ew of the Physician's Orders of the Physician's	{F 221}	A. Resident #3 was every restraint evaluation and restraint was concidered. Need for reviewed by nursing pharmacy consultant director, and adminion restraint eliminate appropriate action to restraint and restraint completed 10/20/11. B. All residents with refor restraint have the adversely affected by process. Residents & pre-restraint assess be completed at time and restraint eliminate discussed in sub QA medical symptom have the adversely affected by process. Residents of the week meetings & complete Interventions and/or discussed at the following will be made not already done. D. Nursing management director, rehab, phar social service staff wand prn to review apeffectiveness of interventions in Changes and/or redumade as needed.	was completed ontinued as restraint will be get, therapy, SS, at, medical ristrator & noted tion form with aken. Prent elimination was restraints or need as potential to be by this deficient will be assessed resment form will be assessment form will be a meeting or when as abated. It forms will be ly sub QA red at that time. It changes will be owing meeting & red at that time if the macy consultant, will meet weekly opropriateness and reventions and formation.	11/11/11	

Nov. 29. 2011 9:00AM
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDIC. D SERVICES

No. 7203PRII^P. 6: 11/15/2011 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION			(X3) DATE SURVEY COMPLETED		
		445141	B. WING		R 11/10/2011	
	ROVIDER OR SUPPLIES			TREET ADDRESS, CITY, STATE, ZIP COU 2910 PEERLESS RD CLEVELAND, TN 37312)É	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TAYEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE COMPLETION	
{F 221}	bilateral hand mit observations on 0 and at 3:40 p.m., Station, revealed wheelchair with the place.	page 2 tens in place. Further Dotober 19, 2011, at 8:00 a.m. at the Wing Two Nurses' the resident sitting in the ne bilateral hand mittens in	{F 221	}		
{F 225} SS≐D	18, 2011, at 12:08 Station, confirmed place to prevent to G-Tube out and to pre-restraint asse- reduction assessing	p.m., in the Wing Two Nurses'd the bilateral mittens were in the resident from pulling the ne facility failed to complete a ressment and a physical restraint ment for the hand mittens.	{F 225	reviewed accounts July 25 given by nurse and CNA o	nager , 2011 n duty	
	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.			during initial discover. AI reviewed account on July 2 Reopened investigation 10 ADON re-interviewed nur. CNA's on duty during init discovery. Investigation we completed 11/1/11. No other was required. No intention occurred based on resident and reaction to others was no further incident of this trecurred. Abuse coordinat reviewed all documentation	25, 2011. /28/11. ses and jal /as ner action nal injury behavior unchanged, type has or	
	involving mistreat including injuries of misappropriation of immediately to the to other officials in through established	ensure that all alleged violations ment, neglect, or abuse, of unknown source and of resident property are reported administrator of the facility and accordance with State law ed procedures (including to the certification agency).		11/1/11 of investigation an was substantiated per clinic assessment. The medical c was notified by DON on O 2011. NP was notified by October 28, 2011. Medica	d no abuse cal lirector ctober 25, DON on	

		AMND HUMAN SERVICES			No. /2	OBERILL	/: 11/15/2011 w APPROVED
	RS FOR MEDICARE						O. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IULTIPLE LDING	CONSTRUCTION	(X3) DATE COMP	SURVEY
		445141	B. WII	NG		11	R /40/2044
NAME OF F	PROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE		/10/2011
BRADLE	Y HEALTH CARE & R	EHAB		2910	PEERLESS RD /ELAND, TN 37312		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	x	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO TH	OULD BE	(X5) COMPLETION DATE
{F 225}			{F 2	25}	& NP were notified of investi	eation	
	violations are thorou prevent further pote investigation is in pr	ogress. estigations must be reported			completion on 11/8/11 by DC further orders were given. St guardian was notified 11/1/11 In-servicing on abuse policy, unknown origin, and behavior management policy began on	oN. No ate	
	representative and t with State law (inclu- certification agency) incident, and if the a	o other officials in accordance ding to the State survey and within 5 working days of the lleged violation is verified to action must be taken.			10/28/11 and all staff were in serviced by 11/7/11 unless on vacation or leave and they wi serviced on date of return to valid agency staff will be in-ser prior to work. Revised abuse	ll be in- vork. viced policy	
	by: Based on medical reinvestigation review, the facility failed to the report an injury of unforty-nine residents not thoroughly investigunknown origin place jeopardy. Immediate which the provider's nore requirements of is likely to cause, sent or death.	policy review, and interview, coroughly investigate and known origin for one (#12) of eviewed. The facility's failure rate and report an injury of dresident #12 in immediate Jeopardy is a situation in concompliance with one or f participation, has caused or ous harm, injury, impairment		В.	on November 6, 2011 was counknown injuries/accident income to be included in policy. Not information was added. State notified of incident & investig through IRS system on 11/7/1 All residents with incidents of unknown origin have the pote be affected by this deficient p Incident reports from July 22, current were reviewed by AD 11/7/11 and review of 44 unknown origin and review of unknown origin a locidents of unknown origin a being reviewed by nursing management initially (daily as occurrence) and ADON (QA) receives incident, and the	eidents new was gation 1. ntial to rocess. 2011 to ON on nown action. are	
	Compliance on Nover conducted on Novem corrective actions imposed the Impose	a Credible Allegation of mber 8, 2011. A revisit ber 10, 2011, revealed the blemented on November 8, mediate Jeopardy. -225 continues at a "D"			investigation begins immediated abuse coordinator and administration and administration to begin investigation. MD/NP will be notified of each	strator ncident gation.	

DEPNov. 29. 2011H 9:00AMND HUMAN SERVICES

CENTE	RS FOR MEDICARE	E & MEDIC) SERVICES				OMB NO	0. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE S	SURVEY
		445141	B. WIN	IG _			Ř
NAME OF F	PROVIDER OR SUPPLIER					11/	10/2011
	Y HEALTH CARE & I	REHAB		2	REET ADDRESS, CITY, STATE, ZIP CODE 1910 PEERLESS RD CLEVELAND, TN 37312		,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD RE	(X5) COMPLETION DATE
	report an injury of ur forty-nine residents in review, the facility failed to the report and injury of ur forty-nine residents in to thoroughly investigunknown origin place which the provider's more requirements of the require	uve evidence that all alleged ughly investigated, and must ential abuse while the rogress.	{F 22	25}	incident as well as contact per (family). Medical director with notified of any injury, during investigation process. All age (DHS, state & local agencies, enforcement) will be notified allegations, as per facility pol servicing of all staff will be duarterly as scheduled and as incident occurs, in-servicing with done by nursing management coordinator and/or department supervisor. Nurses, nursing management, QA nurse will investigate incidents thorough administrator and abuse coordinator supervisors and st been in-serviced on abuse pollabuse coordinator & nursing management completed 11/7/department supervisors will investigate incidents involving departments along with abuse coordinator and administrator policy will be followed. Abus policy has been revised as of November 6, 2011 to reflect R	ill be the the encies and law of abuse icy. In- one an will be , abuse t aff have icy by 11 and g their Abuse se	
0	Compliance on Nover conducted on Noverr corrective actions import the In-	a Credible Allegation of mber 8, 2011. A revisit ober 10, 2011, revealed the plemented on November 8, mediate Jeopardy.			Injuries/Accidents of Unknow Origin with no new informatic added & any identification of related to mistreatment, abuse	n on injuries	

DEP,Nov. 29. 2011H 9:00AMND HUMAN SERVICES

No. 7203PRIIP. 9: 11/15/2011 Nov. 29. 2011 9:01AM
DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDIC, > SERVIÇES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/ÇLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 445141 11/10/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2910 PEERLESS RD **BRADLEY HEALTH CARE & REHAB** CLEVELAND, TN 37312 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (X4) ID PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) {F 225} Continued From page 3 {F 225} (F225) The facility must have evidence that all alleged neglect will be investigated per abuse violations are thoroughly investigated, and must policy. prevent further potential abuse while the C. QA nurse will investigate each investigation is in progress. incident of unknown origin immediately upon receipt. Nurses & The results of all investigations must be reported nurse management will begin the to the administrator or his designated investigation immediately upon representative and to other officials in accordance occurrence/discovery. Based on with State law (including to the State survey and initial investigation with certification agency) within 5 working days of the administrator and abuse coordinator incident, and if the alleged violation is verified receiving notification of incident and appropriate corrective action must be taken. MD/NP & family notification, other entities (DHS, state agencies, & local law enforcement) will be notified per facility policy. Incident reports will This REQUIREMENT is not met as evidenced be trended in QA monthly as to unknown, conclusion, & type of Based on medical record review, facility injury and intervention. Trending investigation review, policy review, and interview. results will be a QA audit with the facility failed to thoroughly investigate and interventions taken to decrease report an injury of unknown origin for one (#12) of common incidents. Members of QA forty-nine residents reviewed. The facility's failure committee are: Administrator, to thoroughly investigate and report an injury of medical director, DON, ADON, unknown origin placed resident #12 in immediate clinical managers, pharmacy jeopardy. Immediate Jeopardy is a situation in consultant, activities director or which the provider's noncompliance with one or

The facility provided a Credible Allegation of Compliance on November 8, 2011. A revisit

more requirements of participation, has caused or

is likely to cause, serious harm, injury, impairment

conducted on November 10, 2011, revealed the corrective actions implemented on November 8.

2011, removed the Immediate Jeopardy. Non-compliance for F-225 continues at a "D"

or death.

findings.

representative, treatment nurse,

restorative nurse, social service

director or representative and any

other staff requested to attend as situation dictates based on QA

DEPARTMENT 2011 HE STAND HUN'N SERVICES CENTERS FOR MEDICARE & MEDIC. SERVICES

No. 7203 PRIP. 10 11/15/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
	_	445141	B, WING			R 11/10/2011	
	ROVIDER OR SUPPLIER Y HEALTH CARE &		ş	TREET ADDRESS, CITY, STATE, ZIP 2910 PEERLESS RD CLEVELAND, TN 37312	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
{F 225}	level citation (pote harm). Validation of the Compliance was a record review, revious eling Social administrative state of a completed invention or the findings and convestigations of founknown origin. To methods adopted all injuries of unknown all responsible parto a conclusion, a trend the injuries. policies/procedure investigation of injuried adopted as part of	age 4 Intial for more than minimal Interedible Allegation of accomplished through medical iew of facility policy, interview with the Licensed Worker, nurses, and if. The facility provided evidence restigation of the bruising of resident #12. In addition, the of Nursing (ADON) provided conclusions from the porty-four additional injuries of the ADON provided the to facilitate the identification of the system to track and the system to track and The facility provided new including a policy for uries of unknown origin the abuse policy, The facility of in-service education for all	{F 225	(F225) D. Incidents will be review discussed in the weekly nursing admin., rehab d rep., pharmacy consults director, administrator, appropriate staff accord of incident.	meeting with epartment int, medical and any other		
SS=D	level until it provide correction to include ensure the deficienthe facility's corrective ensured and evaluation of the facility's corrective ensured and evaluation of the facility's correction of the facility's correction of the facility's correction of the facility's correction of the facility in the facility in the facility is a second of the facility of the facility in the facility in the facility is a second of the facility in the facility in the facility is a second of the facility in the facility in the facility is a second of the facility in the facility in the facility is a second of the facility in the facility in the facility is a second of the facility in the facility in the facility is correct the facility in the facility in the facility is correct the facility in the facility in the facility is correct the facility in the facility in the facility is correct the facility in the facility in the facility in the facility is correct the facility in the facility in the facility is correct the facility in the facility in the facility in the facility is correct the facility in th	pain out of compliance at a "D" es an acceptable plan of ele continued monitoring to est practice does not recur and tive measure could be estated by the Quality Assurance of AND RESPECT OF	(F 241	}			
		environment that maintains or					

DEPANOV. 29. 2011 9:01AM HUMAN SERVICES No. 7203PRIMP. 1111/15/2011 FURIN APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICA 3ERVICES (X3) DATE SURVEY (X1) PRÓVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 445141 11/10/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2910 PEERLESS RD BRADLEY HEALTH CARE & REHAB CLEVELAND, TN 37312 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) A. Resident #19 will not receive meds in 11/14/11 {F 241} Continued From page 5 {F 241} dining room which compromise dignity enhances each resident's dignity and respect in (only po meds). full recognition of his or her individuality. B. All residents in dining rooms have the potential to be adversely affected by this deficient process. In-servicing This REQUIREMENT is not met as evidenced On med pass in dining room and by: compliance rounds by nursing Based on medical record review, observation, administration was completed by and interview, the facility failed to maintain dignity November 14, 2011 and is ongoing. for one (#19) of forty-nine residents reviewed. C. Compliance rounds weekly and prn by nursing administration will ensure The findings included: compliance with med administration in dining rooms. Resident #19 was admitted to the facility on June D. Weekly and prn compliance rounds 4, 2010, with diagnoses including Atrial by nursing administration and med Fibrillation, Depressive Disorder, Osteoporosis, rounds with pharmacy consultant will Chronic Airway Obstruction, Diabetes, and Gout. be ongoing and compliance assured. Medical record review of the Minimum Data Set dated August 30, 2011, revealed the resident was independent with daily decision making. Observation on October 19, 2011, at 8:20 a.m.,

the resident's left arm.

revealed resident the seated at a table with three other residents eating the breakfast meal.

Continued observation revealed Licensed Practical Nurse (LPN) #1 approached the resident and administered nasal spray into both nostrils and administered an insulin injection into

Interview on October 20, 2011, at 9:20 a.m., with the resident, in the resident's room, revealed the resident did not like to receive the nasal spray and insulin injection, in the dining room.

Interview on October 19, 2011, at 9:20 a.m., with the Director of Nursing (DON), in the DON's office confirmed the resident's dignity was not

No. 7203 F. 12PPROVED DEPANOV. 29. 2011E 9:01AMID HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICA (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING 11/10/2011 445141 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2910 PEERLESS RD **BRADLEY HEALTH CARE & REHAB** CLEVELAND, TN 37312 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) {F 241} {F 241} Continued From page 6 maintained. {F 246} {F 246} 483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES SS=D A. Resident #3 had an appropriate 11/11/11 appropriate position sensitive call A resident has the right to reside and receive light placed on 10/25/11. services in the facility with reasonable B. All residents unable to use traditional accommodations of individual needs and call lights have the potential to be preferences, except when the health or safety of adversely affected by this deficient the individual or other residents would be process. All residents were reviewed endangered. by nursing management with appropriate call lights in place. Residents will be identified by nursing assessment on admission, This REQUIREMENT is not met as evidenced quarterly, and prn and an appropriate call light will be put in place. Based on medical record review, observation, Nursing assessment on admission, and interview, the facility failed to ensure the call weekly, monthly, & with change of light had been adapted for use for one resident condition will be performed. If (#3) of forty-nine residents reviewed. resident is identified as unable to use call light nursing with rehab The findings included: assessment will determine appropriate call light and it will be Resident #3 was admitted to the facility on July placed. 2007, with diagnoses including Paraplegia, D. Nursing management will conduct Brain Injury, and Seizure Disorder. compliance rounds weekly and will review resident ability to use

Medical record review of the Minimum Data Set

(MDS) dated September 23, 2011, revealed the

independent for decision making, and behavioral symptoms occurred four to six days a week.

resident was totally dependent for transfers,

Medical record review of the Falls Prevention Program Interventions dated March 10, 2010, and

last updated March 12, 2011, revealed... " hand mittens on at all times...call light in reach and encourage resident to call for assistance..."

appropriate call light with daily

observation, weekly compliance

rounds & quarterly CP meetings.

DEP/Nov. 29. 2011 12 9:02AM ND HUMAN SERVICES CENTERS FOR MEDICARE & MEDIC. SERVICES No. 7203prii^P. 13 11/15/2011 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		445141	B. WIN	۱G		R 11/10/2011	
	PROVIDER OR SUPPLIER	REHAB	-	291	ET ADDRESS, CITY, STATE, ZIP CODE 10 PEERLESS RD EVELAND, TN 37312	147	10/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE
{F 246}	Medical record revi of Care dated July falls R/T (related to mobilitykeep call bed"	ew of the Interdisciplinary Plan 5, 2011, revealed "At risk for) impaired physical ight within reach while in	{F 2	46}			
Medical record review of the Physician's Orders dated October 1, 2011, revealed "keep mittens on at all times" Observations on October 18, 2011, at 6:00 a.m.,							
	in the resident's roo in the bed, bilateral	ctober 18, 2011, at 6:00 a.m., m, revealed the resident lying hand mittens in place, a floor button call light fied to the					
	October 20, 2011, a Nurses' Station, con were in place at all the bed, the residen attention, and the rethe call light with the interview confirmed call light the residen mittens were in place.						
(F 250) S\$=E	The facility must pro services to attain or	provide medically-related social or maintain the highest		50} A	A. Resident #12 has had a behave component added to her Care 10/28/11 by social service assigned to that resident. After director (LCSW) assessed resident.	Plan stant r SS	11/11/11
	well-being of each re	mental, and psychosocial esident. T is not met as evidenced			on 10/28/11 an individualized behavior management plan wa formulated, and then SS direct serviced nursing staff on plan placed plan in chart on 10/28/1 also copy of plan placed in Be	written s or in- and 1 and	

	v. 29. 2011 ₄ ; 9:02 RS FOR MEDICARE	AMND HUMAN SERVICES & MEDIC/ SERVICES			No. 7203 Kirp.		
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE S	ETED	
		445141	B. WIN	G	11/	R 10/2011	
	ROVIDER OR SUPPLIER Y HEALTH CARE & F	REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 2910 PEERLESS RD CLEVELAND, TN 37312				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			COMPLETION DATE	
	and interview, the firservices adequate residents (#12, #15 reviewed with behat the facility's failure adequate to address behaviors placed the in Immediate Jeopa provider's noncomprequirements of partikely to cause serio death). The facility provided Compliance on Nove corrective actions in 2011, removed the Non-compliance for citation (potential for Compliance was accrecord review, review observation, and intercompliance for compliance was accrecord review, review observation, and intercompliance of in-service the adopted behavior specific resident behavior specific resident behavior weekend for resident reviewed for reviewed for reviewed for reviewed for reviewed for re	record review, observation, acility failed to provide social to meet the needs of four , #27, & #30) of four residents viors affecting other residents. to provide social services is the resident to resident e residents on Wing I and IV and (situation in which a diance with one or more ticipation has caused, or is us harm, injury, impairment or I a Credible Allegation of ember 8, 2011. A revisit mber 10, 2011, revealed the aplemented on November 8, Immediate Jeopardy. F-250 continues at a "E" level of more than minimal harm). Redible Allegation of complished through medical woof facility policy, erview with the Licensed Worker, nurses, and The facility provided new	{F 25	Sheets book at nurses Resident #15 has had component added to h 10/27/11 by social ser assigned to that reside service director (LCS) resident, on 10/27/11a individualized written management plan was then social service dir serviced nursing staff placed plan in chart or One on one was alread continued until out to unrelated medical issu Resident #27 has had component added to h 10/28/11 by social ser assigned to that reside service director (LCS) resident, an individual behavior management formulated and then so director in-serviced nu plan and placed plan ir 10/28/11. Resident #30 has had a component added to hi 10/28/11 by social serv assigned to that resider service director (LCS) resident, an individuali behavior management formulated and then so director in-serviced nur formulated and then so director in-serviced nur formulated and then so director in-serviced nur	a behavior his care plan rvices assistant ent. After social W) assessed an hehavior formulated and ector in- on plan and hospital for les on 11/3/11. dy in place and hospital for les on 11/3/11. a behavior is care plan rvices assistant ent. After social W) assessed ized written plan was pocial service ersing staff on hehavior is care plan vices assistant ht. After social with a behavior is care plan rices assistant hehavior is care plan vices assistant hehavior		

No. 7203'RINP 15 1/15/2011 DEPANOV. 29. 2011E, 9:02AMND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICA. JERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING R B. WING 445141 11/10/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2910 PEERLESS RD **BRADLEY HEALTH CARE & REHAB** CLEVELAND, TN 37312 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) Continued From page 8 {F 250} {F 250} plan and placed plan in chart on Based on medical record review, observation, 10/28/11. In-servicing on behavior and interview, the facility failed to provide social management policy, abuse policy, & services adequate to meet the needs of four incidents of unknown origin began on residents (#12, #15, #27, & #30) of four residents 10/28/11 and all staff were inreviewed with behaviors affecting other residents. serviced by 11/7/11 unless on vacation or leave and they will be in-The facility's failure to provide social services serviced on date of return to work. adequate to address the resident to resident All agency staff will be in-serviced behaviors placed the residents on Wing I and IV prior to work. in Immediate Jeopardy (situation in which a B. Residents who exhibit intrusive, provider's noncompliance with one or more aggressive, reactive tendencies will requirements of participation has caused, or is be assessed by social service likely to cause serious harm, injury, impairment or department by 11/7/11 and care death). planned after assessment on 11/7/11. In-servicing of updated interventions The facility provided a Credible Allegation of to direct care staff by social service Compliance on November 8, 2011. A revisit staff was completed on 11/8/11. Staff conducted on November 10, 2011, revealed the on vacation or leave will be incorrective actions implemented on November 8, serviced on date of return to work. 2011, removed the Immediate Jeopardy. All agency staff will be in-serviced Non-compliance for F-250 continues at a "E" level prior to work. Also, any resident citation (potential for more than minimal harm). upon admission who has a history of similar behaviors will be assessed by Validation of the Credible Allegation of social service director and/or Compliance was accomplished through medical assistants as part of the social history record review, review of facility policy, during the admission process. The observation, and interview with the Licensed social service director or assistant Counseling Social Worker, nurses, and assigned will assess/interview administrative staff. The facility provided new resident and direct care staff to policies/procedures including a policy for

Behavior Management. The facility provided

evidence of in-service education for all staff for

specific resident behavior management plans,

The individual behavior management plans and

reviewed for residents #12, 27, and 30. Resident #15 had been dismissed from the facility. In

the coinciding comprehensive care plans were

the adopted behavior management policy and for

formulate CP and/or behavior

management plan within 5 days of

admission. Social service director

and/or assistant will notify nursing

staff immediately on day of new

behaviors. Copy of social history

admission or prior of potential

DEPARTMENT OF HEALTH AND HUMAT'SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES No. 7203PRINP. 1611/15/2011 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILI	DING	RUCTION	COMPLE	ETED
		445141	B. WING	s			R 0/2011
	PROVIDER OR SUPPLIER Y HEALTH CARE & F	REHAB		2910 PEERLI	SS, CITY, STATE, ZIP CODE ESS RO ID, TN 37312		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EAC	ROVIDER'S PLAN OF CORRECTIVE ACTION SH S-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
{F 250}	Based on medical and interview, the fiservices adequate residents (#12, #15 reviewed with behated adequate to address behaviors placed the informediate Jeopa provider's noncomprequirements of palikely to cause serio death). The facility provider Compliance on Nove conducted on Nove corrective actions in 2011, removed the Non-compliance for citation (potential for Validation of the Crompliance was acrecord review, reviewed servation, and into Counseling Social Validation of the Crompliance of in-servithe adopted behavior specific resident be The individual behatthe coinciding compreviewed for resident	record review, observation, acility failed to provide social to meet the needs of four is, #27, & #30) of four residents eviors affecting other residents. It to provide social services as the resident to resident ne residents on Wing I and IV ardy (situation in which a pliance with one or more ricipation has caused, or is pus harm, injury, impairment or a Credible Allegation of the resident on November 8, 2011. A revisit ember 10, 2011, revealed the emplemented on November 8, Immediate Jeopardy. F-250 continues at a "E" level or more than minimal harm). Redible Allegation of the recomplished through medical level of facility policy, rerview with the Licensed	{F 25	and previes servi indiv Psyc and for the control of	be provided for nurses to place in 24 hour report to eved every shift. Nursing ice staff will be involved widualizing plan for resident NP may be involved with the constant of the property were meeting or if behavior entereds assessment and adventions. New intervent will be in-serviced by side staff. Progress will be seed by behavior monitots, decreased reported in the care staff observations, views with residents and reding behaviors. Social will assess daily those retified by incidents. Infinite consisting of nursing agement, social service supply staff, dietary staff, inistrator, medical direct macy consultant. Monit be done through weekly shavior management plan vior monitoring sheets, aryation. Behavior Mana will also be reviewed due terly assessment and care	o be ng, social l in lent. with MD t, Social edical or ek at sub scalates iditional tions in social oe wring acidents, e staff & and d families service esident ots will n & ug staff, or, and oring review ns, and daily ngement uring	

DEP/N CENT	ov. 29. 2011 _H 9:03 ERS FOR MEDICARE	AMND HUMAN SERVICES E. & MEDIC. SERVICES		No. 72	FORM	7 11/15/2011 APPROVED 0. 0938-0391
STATEME AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	DETIPLE CONSTRUCTION DING	(X3) DATE S	SURVEY
		446141	B. WING	3	11/	R 10/2011
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BRADL	EY HEALTH CARE & F	REHAB		2910 PEERLESS RD CLEVELAND, TN 37312		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		IOUI D BE	COMPLETION DATE
{F 278} SS=D	addition, the behavisingle resident president president president president president president plant the havior was insent the resident on Nov confirmed each of the behavior management station with an accorrection with an accorrection to include ensure the deficient the facility's correcting the facility's correcting committee. 483.20(g) - (j) ASSE ACCURACY/COOR The assessment muresident's status. A registered nurse meach assessment with participation of health A registered nurse massessment is compiled that portion of the assessment must sign that portion are must sign that po	for management plan for the senting with a new behavior on was reviewed. The behavior of address this resident's new viced for the staff caring for ember 9, 2011. Observation hese residents also had the ent plans filed at each nursing impanyling grid to facilitate with out of compliance at an "E" an acceptable plan of a continued monitoring to practice does not recur and we measure could be atted by the Quality Assurance in SSMENT DINATION/CERTIFIED ast accurately reflect the instructionals. The sign and certify that the leted.	{F 278	discussions/updates. Behavior issues will be logged on a Betracking form and reviewed from an as each incident occurs and we reviewed at weekly meeting a trends & interventions will be reported at monthly QA meet nurse will track & trend behavissues.	havior or trends vill be and ong. QA	

DEP/Nov. 29. 2011 9:03AM SERVICES

CENTERS FOR MEDICARE & MEDIC. SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING

No. 7203 PRIP. 18 11/15/2011 FORM APPROVED OMB NO. 0938-0391

(F 278) Continued From page 10 Subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure the Minimum Data Set (MDS) was accurate for three (#14, #15, and #31) of forty-nine residents reviewed. The findings included: Resident #14 was admitted to the facility on September 10, 2007, with diagnoses including Carebrovascular Accident, Motor Vehicle Accident with Traumatic Brain Injury. Convulsions, and Rosacea. Review of the medical record revealed no documentation the resident had experienced a fall without injury, since the prior MDS assessment.		FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
### PROPERTY TAGE CAST DEPERTY SUMMARY STATEMENT OF DEFICIENCIES CLEVELAND, TN 37312			445141	B. WIN	G			
FREFIX TAG TAG TAG TAG TAG TAG			REHAB		2910	PEERLESS RD		
Subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. Clinical disagreement does not constitute a material and false statement. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure the Minimum Data Set (MDS) was accurate for three (#14, #15, and #31) of forty-nine residents reviewed. The findings included: Resident #14 was admitted to the facility on September 10, 2007, with diagnoses including Cerebrovascular Accident, Motor Vehicle Accident with Traumatic Brain Injury, Convulsions, and Rosacea. Medical record review of the MDS dated October 11, 2011, revealed the resident had experienced a fall without injury, since the prior MDS assessment. Review of the medical record revealed no documentation the resident had experienced a	PREFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREFI	×	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	(X5) COMPLETION DATE
Interview on October 18, 2011, at 2:00 p.m., with the Director of Nursing, in the file room,		subject to a civil mo \$1,000 for each ass willfully and knowin to certify a material resident assessment penalty of not more assessment. Clinical disagreeme material and false so the facility failed to (MDS) was accurate of forty-nine resident the facility failed to (MDS) was accurate of forty-nine resident the findings include Resident #14 was a September 10, 2000 Cerebrovascular Accident with Traum Convulsions, and Reference of fall without injury, assessment. Review of the medic documentation the refall.	eney penalty of not more than sessment; or an individual who gly causes another individual and false statement in a not is subject to a civil money than \$5,000 for each ent does not constitute a statement. In it is not met as evidenced record review and interview, ensure the Minimum Data Set to for three (#14, #15, and #31) ats reviewed. In its revie	{F 2	B.	was corrected on 10/20/11 to a no fall occurred. Resident #15 MDS dated 10/11/11 did not redementia related to severity of diagnosis but CP was completed dementia on 11/1/11. Resident MDS dated 9/27/11 was correct 10/24/11 to reflect a fall had occurred. All residents have the potential adversely affected by this deficiencess. MDS will be reviewed completed prior to submission IDT and any changes needed waddressed. The dementia diagn will be listed as diagnosis in an which will place dementia on Monot captured otherwise. Nursing will notify MDS nurse verbally during weekly sub QA meeting and in writing by upda roster at least weekly. MDS will be reviewed quarterly change of condition for accurace IDT. Nursing management and nurse to monitor for complete assessment accuracy & MDS resident in the monitor for complete assessment accuracy &	reflect 's	11/11/11

DEPANOV. 29. 2011 9:03AM HUMAN SERVICES No. 7203PRIP. 1911/15/2011 FORM APPROVED CENTERS FOR MEDICARE & MEDICA. SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 445141 11/10/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2910 PEERLESS RD BRADLEY HEALTH CARE & REHAB CLEVELAND, TN 37312 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) {F 278} Continued From page 11 (F 278) confirmed the resident had not experienced a fall since the prior assessment, and confirmed the MDS dated October 11, 2011, was not accurate. Resident #15 was admitted to the facility on July 9. 2011, with diagnoses including Dementia, Ischemic Heart Disease, and Pressure Ulcer. Medical record review of the MDS dated July 13. 2011, and October 11, 2011, revealed no documentation of the Dementia diagnosis. Interview on October 19, 2011, at 10:00 a.m., with Licensed Practical Nurse (LPN) #2, in the conference room, confirmed the MDS dated July

with Licensed Practical Nurse (LPN) #2, in the conference room, confirmed the MDS dated July 13, 2011, did not include the resident's diagnosis of Dementia.

Resident #31 was admitted to the facility on April 2, 2001, with diagnoses including Personal History of Fall, Peripheral Vascular Disease, and Blepharitis.

Medical record review of the MDS dated September 27, 2011, revealed the resident had not experienced a fall since the prior MDS assessment.

Medical record review of the nursing notes dated August 8, 2011, revealed "CNA (Certified Nursing Assistant) came to...et (and) stated 'pt. (patient) is in the floor.' Upon entering DR (dining room) pt was lying on (L) side...(no) inj. (Injury) noted..."

Interview on October 21, 2011, at 9:35 a.m., with LPN #2, in the conference room, confirmed the MDS dated September, 27, 2011, did not reflect the resident's fall on August 8, 2011, and

DEPARTMENT OF HEALTH AND HULF IN SERVICES
CENTERS FOR MEDICARE & MEDIC SERVICES

No. 7203PRIIP. 2011/15/2011 FOKM APPROVED OMB NO. 0938-0391

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING			(X3) DATE SURVEY COMPLETED		
		445141	B. WING_		R 11/10/2011	
	ROVIDER OR SUPPLIER	REHAB		TREET ADDRESS, CITY, STATE, ZIP CODE 2910 PEERLESS RD CLEVELAND, TN 37312		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION	
{F 278} {F 280} \$S=E	confirmed the MDS 483.20(d)(3), 483.1 PARTICIPATE PLATE PLAT	was not accurate. O(k)(2) RIGHT TO ANNING CARE-REVISE CP The right, unless adjudged erwise found to be represented in the laws of the State, to ing care and treatment or	{F 278		ated n lated on sistant icing on o direct cial monitor sthrough ncident nd is are of their ing is questions gers at	
9	by: Based on medical investigation review the facility failed to care plan addressir symptoms for five residents (#12, #15 facility failed to care number of assistant	record review, facility y, observation, and interview assess for and implement a ng behavior signs and y #24, #27, and #30) and the plan for the assessed ts required for transfer for one y-nine residents reviewed.		10/27/11. Care plan was upda 10/27/11 by social service ass assigned to resident. In-service behavior management plan to care staff was 10/28/11 by social service director. One on one currently in place while up in staff was scheduled, document reflects the continuation of one and assigned staff was relied by other assigned staff for breeded.	ated on sistant cing on direct cial care was w/c, ntation lieved	

DEPANOV. 29. 2011 E 9:03AMND HUMAN SERVICES CENTERS FOR MEDICARE & MEDIC, SERVICES No. 7203PRIMP. 2111/15/2011 FUKIN APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) DATE S COMPL	
)		445141	B. WING		111	R 10/2011
	PROVIDER OR SUPPLIER	EHAB	s	TREET ADDRESS, CITY, STATE, ZIP COI 2910 PEERLESS RD CLEVELAND, TN 37312		10/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
{F 282} SS=D	The facility's failure careplan to supervisithe resident's unsaft wheelchair placed the IV in Immediate Jiprovider's noncomprequirements of partikely to cause serior death). The facility provided Compliance on Nove corrective actions in 2011, removed the Innon-compliance for citation (potential for Validation of the Crecompliance was accrecord review, review and interview with the Social Worker, nurse The facility provided management plans a comprehensive care residents #12, 24, 25 been dismissed from The facility will remain level until it provides correction to include ensure the deficient the facility's corrective reviewed and evaluate Committee.	to assess and implement a se resident #15 and address to behaviors in the use of the he residents on Wing #1 and adoption in which a liance with one or more ficipation has caused, or is us harm, injury, impairment or a Credible Allegation of the ember 8, 2011. A revisit mber 10, 2011, revealed the explemented on November 8, mmediate Jeopardy. F-280 continues at a "E" level of more than minimal harm). Indible Allegation of the complished through medical work of care plans, observation, the Licensed Counseling the plans were reviewed for and the coinciding plans were reviewed for and 30. Resident #15 had the facility. In out of compliance at an "E" an acceptable plan of continued monitoring to practice does not recur and the measure could be ted by the Quality Assurance.	{F 282}	unrelated medical issue as Restraint was placed on C nursing management and regarding self harm & neg interactions by social assis 10/27/11. Nursing manage staff will monitor effective interventions through beha monitoring sheets, inciden daily observations, and int Monitoring sheets are com nurses as part of their doct and in-servicing is done or orientation and any questic answered by nurse manage time. Resident #24 — Bruising to related to wheelchair has be assessed by nursing and redifferent w/c was issued to on 11/4/11. This w/c is tag resident name & staff in-se CM on chair & positioning 11/4/11. Clinical Manager to CNA CP also on 11/4/11. Nursing staff will observe every 2 hours on rounds & regarding positioning in w/resident regarding comfort, and prevention has been ad by nursing management aff assessment as of 10/31/11. Resident #27 — The CP has updated to reflect behaviors interventions by social service.	of 11/3/11. P by behaviors lative stant on ement & SS eness of avior at reports, erviews. unletted by unentation, n ons are ers at any breast leen hab and a leesident leged with erviced by son lat least prin c and ask Bruising lded to CP leer been s and	

DEPA	ov. 29. 2011 _€ 9:04	AMND HUMAN SERVICES			No. 72	03KINP	2 PRÓVED
CENTE	RS FOR MEDICARE	& MEDIC/ SERVICES				OMB NO.	0938-0391
STATEMEN AND PLAN (F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		445141	B. WING			**************************************	2
NAME OF F	RÓVÍDER OR SUPPLIER	I				11/1	0/2011
	Y HEALTH CARE & F	DENAG	S'		ADDRESS, CITY, STATE, ZIP CODE PEERLESS RD		
DIVADEL	THEALTH OAKE OF	LIND		CLE	/ELAND, TN 37312		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
{F 280}	The facility's failure careplan to supervithe resident's unsawheelchair placed the IV in Immediate Japrovider's noncomprequirements of partikely to cause serio death). The facility provider Compliance on Nove corrective actions in 2011, removed the Non-compliance for citation (potential for Validation of the Crompliance was acrecord review, reviewed interview with the Social Worker, nursathe facility provided management plans comprehensive care residents #12, 24, 2 been dismissed from The facility will remain level until it provides correction to include ensure the deficient the facility's correction to include ensure the deficient the facility is correction.	to assess and implement a se resident #15 and address fe behaviors in the use of the the residents on Wing # I and leopardy (situation in which a pliance with one or more ricipation has caused, or is ous harm, injury, impairment or dia Credible Allegation of the rember 8, 2011. A revisit ember 10, 2011, revealed the mplemented on November 8, Immediate Jeopardy. F-280 continues at a "E" level or more than minimal harm). Redible Allegation of complished through medical ew of care plans, observation, the Licensed Counseling ses, and administrative staff. I individual behavior and the coinciding a plans were reviewed for 17, and 30. Resident #15 had in the facility. All in out of compliance at an "E" is an acceptable plan of a continued monitoring to practice does not recur and the residue of the Quality Assurance at the plans of the continued monitoring to practice does not recur and the cated by the Quality Assurance	{F 280	В.	assistant on 10/28/11 and beh management plan was implemed by social service director and serviced nursing staff on 10/2 Resident #30 — Behavior man plan was formulated after assident was formulated after assident was formulated CP to address behaviors on 10/28/11. So service assistant updated CP to address behaviors on 10/28/11 Resident #8 —This resident was person transfer as of 6/3/11 & staff was in-serviced by rehabilitation of the staff was in-serviced by rehabilitation. CP updated to reflect transeded. Resident expired 11/1 In-servicing on abuse policy, behavior management policy, incidents of unknown origin phegan on 10/28/11 and all staff in-serviced by 11/7/11 unless vacation or leave and they will serviced on date of return to wall agency staff will be in-serviced by affected by this definition or leave and the potential adversely affected by this definition or leave and the potential adversely affected by this definition or leave the potential adversely affected by this definition or leave will be in-servicing of updates to direct staff done by nursing management, and updates completed 11/8/11. All staff of vacation or leave will be in-serviced or	nented in- 8/11. agement essment iced cial o 1. us a 4 nursing on that ensfer 13/11. & olicy ff to be on 1 be in- ork. viced lt to be cient viewed DS rsing upleted. et care nent n	
JE 2821	483 20(k)(3)(ii) SER	VICES BY OUALIEIED	/F 2821	.1		1	1

SS=D PERSONS/PER CARE PLAN

	. 2011E 9:04 OR MEDICARE	AMND HUMAN SERVICES & MEDIC SERVICES			No. 72		2311/15/2011 PPROVED 0. 0938-0391
STATEMENT OF D AND PLAN OF COI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IULTIPLE CONSTRUCT	TON	(X3) DATE	SURVEY LETED
		445141	B. Wii	NG		11	R /10/2011
NAME OF PROVID	ER OR SUPPLIER			STREET ADDRESS. O	CITY, STATE, ZIP CODE		10/2011
BRADLEY HE	ALTH CARE & F	REHAB		2910 PEERLESS CLEVELAND, T	RD		q
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH Ç	DER'S PLAN OF CORRECTIVE ACTION SHO FERENCED TO THE APPI DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
The care the whe # IV provereque likely deal The Common correct the correct th	eplan to supervi- resident's unsai- elchair placed to in Immediate Juder's noncomplirements of pair y to cause serio th). facility provided a pliance on Novelective actions in Immediate Jucted on Novelective actions in Immediate for on (potential for on (potential for on (potential for on the Crepliance was acted review, review with the Worker, nursure facility provided agement plans are the series #12, 24, 21 dismissed from the include the deficient action to include the deficient action to include the deficient action and evaluation in the compliance.	to assess and implement a se resident #15 and address to behaviors in the use of the he residents on Wing # I and eopardy (situation in which a allance with one or more ticipation has caused, or is us harm, injury, impairment or I a Credible Allegation of the ember 8, 2011. A revisit ember 10, 2011, revealed the explemented on November 8, immediate Jeopardy. F-280 continues at a "E" level of more than minimal harm). Edible Allegation of the explemented through medical work of care plans, observation, to Licensed Counseling the explemented through medical work of care plans, observation, to Licensed Counseling to plans were reviewed for 7, and 30. Resident #15 had a the facility. In out of compliance at an "E" an acceptable plan of continued monitoring to practice does not recur and the measure could be ted by the Quality Assurance	{F 28	on date of staff will Resident incident manager and adm interview monitori residents social set assistants required assessme assessme determine (MDS) at for annual discussed attended nursing mostaff, actitherapy stadministre determini CP'd and place. Chaddress puto ADL's intervention-service intervention.	of return to work. All be in-serviced prior to identified by review reports by nurses, nument, social service dinistrator. Also staff ws, review of behavious sheets, and observed during quarterly revivice director and/or s. Residents who are to have an admissioned to have an admissioned ent (MDS), quarterly ent (MDS), resident wed as change of condinct those who are requal assessment (MDS) in weekly CP meeting by IDT team. IDT contangement, social servities staff, dietary straff, restorative nurse fator. All assessments ing an adverse affect interventions will be NA CP's in each closs ertinent areas of CP reand individualized ons. Nursing manages of direct care staff whom are put in place.	to work. w of rrsing irector, ration of iews by who are ition uired will be ngs, ponsist of ervice aff, and s will be put in et will elated ement en	

	v. 29. 2011 E 9:04	AMO HUMAN SERVICES & MEDIC/ SERVICES			No. 7203 FC2	PPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SU COMPLE	(X3) DATE SURVEY COMPLETED	
	٠	445141	B. WING	G	400	R 0/2011	
	ROVIDER OR SUPPLIER Y HEALTH CARE & F	REHAB		STREET ADDRESS, CITY, STATE, ZIP 2910 PEERLESS RD CLEVELAND, TN 37312			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(XS) COMPLETION DATE	
{F 280}	The facility's failure careplan to supervithe resident's unsawheelchair placed # IV in Immediate provider's noncomprequirements of palikely to cause serio death). The facility provide Compliance on Nove corrective actions in 2011, removed the Non-compliance for citation (potential for Validation of the Crompliance was acrecord review, revie and interview with the Social Worker, nursure the facility provided management plans comprehensive car residents #12, 24, 25 been dismissed from The facility will remove until it provided correction to include ensure the deficient the facility's correct reviewed and evaluation Committee.	to assess and implement a lise resident #15 and address fe behaviors in the use of the the residents on Wing # I and deopardy (situation in which a pliance with one or more ricipation has caused, or is bus harm, injury, impairment or d a Credible Allegation of wember 8, 2011. A revisit ember 10, 2011, revealed the implemented on November 8, Immediate Jeopardy. The F-280 continues at a "E" level or more than minimal harm). The dible Allegation of complished through medical lew of care plans, observation, the Licensed Counseling ses, and administrative staff, and the coinciding e plans were reviewed for 27, and 30. Resident #15 had	(F 28	& nurses also aide in conterventions. Transfer by rehab on new admire admits, upon referrations for the content of the content	ers are reviewed ssions, I and annually. Care staff lone on an an anisis after rehab lone on the purpose of the ctiveness of CP vation, using as behavior ident reports a departments. Seentative of the ctiveness of the purpose of the purpose of the purpose of the ctiveness of the purpose of the seen their scope of		
	PERSONS/PER CA		[1 202	-,			

DEP.Nov. 29. 2011H 9:04AMAND HUMAN SERVICES No. 7203 PRIP. 25 11/15/2011 FORM APPROVED CENTERS FOR MEDICARE & MEDIC D SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 445141 11/10/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2910 PEERLESS RD BRADLEY HEALTH CARE & REHAB CLEVELAND, TN 37312 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) COMPLETION DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) {F 282} Continued From page 14 {F 282} The services provided or arranged by the facility A. Resident #18's fluid intake 11/14/11 must be provided by qualified persons in and output is current as of 10/19/11. accordance with each resident's written plan of B. All residents determined to need an I саге. & O per policy and those specifically ordered by MD/NP have the potential to be adversely affected by this This REQUIREMENT is not met as evidenced deficient process. In-servicing of nurses re: I & O policy was Based on medical record review, facility policy completed by November 14, 2011 by review, and interview, the facility failed to nursing management and is ongoing. maintain an accurate record of fluid intake and C. Chart audits and nurses in-services output for one resident (#18) of forty-nine will be conducted by nursing residents reviewed. management to ensure compliance. Residents requiring I & O's will be The findings included: identified and a log will be kept, Resident #18 was admitted to the facility on reviewed by nursing management daily to ensure compliance. December 15, 2010, with diagnoses including Nursing management will review & Left Lower Quadrant Open Abscess, Acute Renal monitor all resident documentation Failure, Sepsis, Chronic Obstructive Pulmonary regarding fluid intake & output and Disease, and Dementia. assure completion of documentation and notification to MD/NP as needed. Medical record review of the resident's care plan updated October 5, 2011, revealed "category problem...Catheter: indwelling...with potential risk of UTI (urinary tract infection) intervention...Change foley...empty foley every

output.

shift and record output..."

Medical record review of the facility intake and output record for resident #18 revealed incomplete documentation September 1, 2011 through October 18, 2011, to provide an

evaluation of the resident's overall fluid intake and

Review of the facility policy for Intake and Output

DEP,Nov. 29. 2011H 9:05AMND HUMAN SERVICES No. 7203 PRIP. 26 11/15/2011 FURM APPROVED CENTERS FOR MEDICARE & MEDIC SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING R B. WING 445141 11/10/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2910 PEERLESS RD BRADLEY HEALTH CARE & REHAB CLEVELAND, TN 37312 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION DATE PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) {F 282} Continued From page 15 {F 282} revealed, " ...total intake for 24 (twenty-four) hour cycle...total output at the end of each tour of duty. Key point: total for 24 hour cycle..." Interview with the Wing I Clinical Manager (CM) and the Director of Nursing, in the CM's office on October 19, 2011, at 8:45 a.m., confirmed the facility policy for intake and output was not followed. {F 312} 483.25(a)(3) ADL CARE PROVIDED FOR {F 312} DEPENDENT RESIDENTS SS=D A. Resident #3 nail care was done on 11/14/11 10/19/11 with all nails trimmed A resident who is unable to carry out activities of and no jagged edges. daily living receives the necessary services to B. All residents have the potential to be maintain good nutrition, grooming, and personal adversely affected by this deficient and oral hygiene. process. Compliance rounds will be completed weekly & prn by nurse/nursing management in regards This REQUIREMENT is not met as evidenced

The findings included:

by:

reviewed.

Resident #3 was admitted to the facility on July 10, 2007, with diagnoses including Paraplegia, Brain Injury, and Seizure Disorder.

Based on medical record review, observation,

and interview, the facility failed to provide nail care for one resident (#3) of forty-nine residents

Medical record review of the Minimum Data Set (MDS) dated September 23, 2011, revealed the resident was totally dependent for transfers and required extensive assistance with all activities of daily living.

to resident care including hygiene & personal appearance. Care needs will be addressed and CNA's & nurses were in-serviced by nursing management re: nail care by November 14, 2011 & ongoing.

C. Nurses and nursing management will conduct weekly/prn compliance rounds to ensure ADL care is provided for all residents according to their level of care.

D. Nursing management will monitor for nail care with compliance rounds weekly & prn and daily observation to ensure care needs are met.

DEP.Nov. 29. 2011 H 9:05AM ND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDIC D SERVICES

No. 7203 PRP. 27 11/15/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	LTIPLE CONSTRUCTION DING	(X3) DATE COMP	SURVEY LETED	
		445141	B. WING		- 11	R 11/10/2011	
	PROVIDER OR SUPPLIER EY HEALTH CARE & F	REHAB		TREET ADDRESS, CITY, STATE, 2 2910 PEERLESS RD CLEVELAND, TN 37312	TVVIII	110/2011	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
SS=D	Observation on Oct the Wing Two Nurs resident had bilater; Licensed Practical I hand mittens; the na jagged, and sharp, indentations observ Interview with Licen October 19, 2011, a Nurses' Station, corprovide nail care. 483.25(d) NO CATHRESTORE BLADDE Based on the reside assessment, the fact resident who enters indwelling catheter is resident's clinical corcatheterization was a who is incontinent of treatment and service infections and to resident to possible. This REQUIREMENT by: Based on medical repolicy/procedure revifailed to provide approne resident (#7) of for the findings included	ober 19, 2011, at 4:12 p.m., at es' Station, revealed the all hand mittens in place; Nurse (LPN) #3 removed the ails on the left hand were long, and there were nail ed in the palm. sed Practical Nurse #3 on at 4:12 p.m., at Wing Two affirmed the facility failed to different to the facility failed to different to the facility without an at the facility without an at the facility without an at the facility without and at the facility and a resident for a much normal bladder. It is not met as evidenced accord review, observation, ew, and interview, the facility opriate incontinence care for orty-nine residents reviewed.	{F 315}		been re-inserviced care on 11/2/11. care was done potential to be this deficient of the perineal leted November anagement and will complete dobserve and prn to newly hired lls check offed by nursing and of smcy of skill. will monitor wledge of skills ngoing in-	11/14/11	

DEPANOV. 29. 2011-L9:05AMND HUMAN SERVICES No. 7203PRIIP. 2811/15/2011 FUKM APPROVED CENTERS FOR MEDICARE & MEDIC SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING R **B. WING** 445141 11/10/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE BRADLEY HEALTH CARE & REHAB 2910 PEERLESS RD CLEVELAND, TN 37312 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) {F 315} Continued From page 17 {F 315} Hypertension, Dementia, Sepsis and Hypothyroidism. Medical record review of the Minimum Data Set (MDS) dated September 13, 2011, revealed the resident scored a 1 on the Brief Interview of Mental Status (BIMS) which indicated the resident had severe cognitive impairment. Further medical record review revealed the resident required extensive assistance with eating, bathing and was incontinent of bladder and bowel. Observation on October 18, 2011, at 6:50 a.m., in the resident's room, revealed two Certified Nurse Assistants (CNAs) providing hygiene carefollowing an episode of bowel and bladder incontinence. While performing perineal care, the CNAs removed the soiled brief, CNA #5 cleaned the resident's perineal area, wiping front to back, then wiped the resident's perineal area back to front two times, using the same solied wash cloth. Further observation revealed CNA # 5 wiped the perineal front to back, dried the area with a dry towel, and placed a clean brief on the resident. Review of the facility's policy and procedure, titled Perineal Care, revealed, "...for a female resident: wash perineal area, wiping from front to back. rinse perineum thoroughly in the same direction, using fresh water and a clean washcloth..."

FORM CMS-2567(02-99) Previous Versions Obsolete

assistance by CNA..."

Medical record review of the Care plan, dated September 16, 2011, revealed, "...provide or assist...with proper peri-care after each pad or brief change. Wipe from front to back to prevent intestinal bacteria from entering urinary tract; full

Event ID: PBF212

Facility ID: TN0601

If continuation sheet Page 18 of 40

DEP, Nov. 29. 2011 H 9:05AM ND HUMAN SERVICES No. 7203 PRIP. 29 11/15/2011 FORM APPROVED CENTERS FOR MEDICARE & MEDIC D SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 445141 11/10/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **BRADLEY HEALTH CARE & REHAB** 2910 PEERLESS RD CLEVELAND, TN 37312 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) {F 315} Continued From page 18 {F 315} Interview with CNA # 5 on October 18, 2011, at 7:00 a.m., in the resident's room, confirmed the perineal area was wiped back to front two times using the soiled wash cloth. Interview with the Director of Nursing (DON), on October 19, 2011, at 9:25 a.m., in the DON office, confirmed incontinence care was not provided according to facility policy. 483.25(e)(2) INCREASE/PREVENT DECREASE {F 318} {F 318} A. Resident # 3's contracture 11/11/11 IN RANGE OF MOTION SS=D Assessment completed on 9/11/11 with no change in function. OT notified and Based on the comprehensive assessment of a reviewed on 10/18/11. Current ROM resident, the facility must ensure that a resident treatment for resident is appropriate per with a limited range of motion receives Restorative & OT. appropriate treatment and services to increase B. All residents with decreased ROM range of motion and/or to prevent further and/or contractures have the potential decrease in range of motion. to be affected by this deficient process. Restorative nursing and OT assess residents with change of condition, hospital stay returns, and This REQUIREMENT is not met as evidenced quarterly. Documentation will reflect Based on medical record review, observation, any changes in ROM and programs will be revised to enhance or maintain and interview, the facility failed to provide treatment and services to prevent further decline current functioning. Residents have in Range of Motion (ROM) for one resident (#3) been assessed by restorative nurse of forty-nine residents reviewed. and OT and no changes are needed. Restorative nurse aides, restorative

September 9, 2011.

The findings included:

Resident #3 was admitted to the facility on July

10, 2007, with diagnoses including Paraplegia,

re-admitted to the facility on September 9, 2011, after a hospital stay from September 7, 2011 to

Brain Injury, and Seizure Disorder and was

place.

nurse, therapy dept. rep., and nursing

management will review resident

level of functioning daily with care.

through monthly QA reports, monthly

assessments, and quarterly CP's with most appropriate intervention put in

DEPANO	v. 29. 2011 _H 9:06 RS FOR MEDICARE	AMND HUMAN SERVICES		No. 72	FURI)() 11/15/2011 II APPROVED
STATEMEN	TO F DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
		445141	B. WING		11/	R 10/2011
	PROVIDER OR SUPPLIER EY HEALTH CARE & F	REHAB	S	TREET ADDRESS, CITY, STATE, ZIP CODE 2910 PEERLESS RD CLEVELAND, TN 37312		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	Medical record reviews assistant living. Medical record reviews assistant living.	ew of the Minimum Data Set mber 23, 2011, revealed the ependent for transfers and se with all activities of daily ew of the Falls Prevention ons dated March 10, 2010, and 12, 2011, revealed hand on at all times. ew of the Interdisciplinary Plan 5, 2011, revealed, ling for Splintingmultiple bilateral hand carrotsOT by) to ensure appropriateness ew of the MADL (activities of daily living) mber 12, 2011, revealed, (bilateral) Hand CarrotB hand mitts not in use" ew of the Restorative Care of September 1-7, 2011 and 8, 2011Gloves Applied do September 19-30, 2011" ew of the Restorative Care of October 2011, revealed, speed of September 19-30, 2011" ew of the Restorative Care of October 2011, revealed, speed of September 19-30, 2011"	{F 318	D. Review of resident functioning be monitored daily, monthly, quarterly by RNA's, restoration nurse, nursing management, of therapy dept. rep. Restorative rehab treatments will be report monthly QA meeting.	& ve t and	

resident's return from the hospital stay on

DEPANOV. 29. 2011-L 9:06AM ND HUMAN SERVICES No. 7203PRIIP. 31 11/15/2011 **FURM APPROVED** CENTERS FOR MEDICARE & MEDIC SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 445141 11/10/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2910 PEERLESS RD **BRADLEY HEALTH CARE & REHAB** CLEVELAND, TN 37312 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (D (X5) COMPLETION DATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) {F 318} Continued From page 20 {F 318} September 9, 2011, splints had only been applied four times. Medical record review of the Restorative Care Comments revealed September 27, 2011. "...resists ROM (range of motion) conts (continues) to be extremely stiff...", September 30, 2011, "...ROM et (and) hand carrots resumed after hosp (hospital) return...cont (continue) as stated...", and October 14, 2011, "...resident conts to wear gloves/mitts on hands unable to place carrots in hands..." Medical record review of Physician's Orders dated October 10, 2011, revealed, "...mittens at all times..." Interview with Licensed Practical Nurse #3 on October 18, 2011, at 11:55 a.m., in the Wing Two Nurses' Station, confirmed the carrots to prevent further decrease in ROM/increase in contractures had not been applied since the resident returned from the hospital and stated, "the new mittens are smaller and the carrots will not fit." Interview with Occupational Therapist on October 18, 2011, at 12:10 p.m., in the therapy room, confirmed the facility failed to assess the resident

FORM CMS-2567(02-99) Previous Versions Obsolete

September 9, 2011.

{F 323}

SS=E

483.25(h) FREE OF ACCIDENT

HAZARDS/SUPERVISION/DEVICES

The facility must ensure that the resident

as is possible; and each resident receives

environment remains as free of accident hazards

adequate supervision and assistance devices to

to prevent further bilateral hand contractures since the resident returned from the hospital on

Event ID: PBF212

Facility ID: TN0801

{F 323}

A. Resident #15 – Due to excessive

wandering and unsafe behaviors in

wheelchair resident sustained skin

self harm or negative interactions -

which at times resulted in skin tears.

One on one began October 20, 2011

tears. Resident was one on one supervision to decrease possibility of

If continuation sheet Page 21 of 40

11/13/11

DEPA	v. 29. 2011 _{1E} 9:06	AMND HUMAN SERVICES & MEDIC SERVICES		No. 720	FURIN	211/15/2011 APPROVED
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			A. BUIL		OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED R	
		445141	B. WING	3		0/2011
BRADLE	PROVIDER OR SUPPLIER EY HEALTH CARE & F	0.0000000000000000000000000000000000000		STREET ADDRESS, CITY, STATE, ZIP CODE 2910 PEERLESS RD CLEVELAND, TN 37312		0/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPROPRIED TO THE APPR	ILD RE	(X5) COMPLETION DATE
{F 323}	Continued From parevent accidents.	ge 21	{F 32	administration & documentation reflects this also. Staff member relieved by other staff members breaks & lunch. Resident went	s were	
	by: Based on medical reports, observation failed to provide sup resident (#15) with be harming self and oth transfer for one resident sustaining a failed to use a mech resident (#3); failed to properly and use an resident (#5); failed to biohazard rooms; an personal alarm for refresidents reviewed.	ecord review, review of facility, and interview the facility ervision to prevent one ehavioral problems from ters; failed to provide a safe dent (#8) which resulted in the a right distal femur fracture; anical lift when transferring to apply a soft belt restaint appropriate transfer for o secure one of seven d failed to activate the esident (#14) of forty-nine	54	hospital 11/3/11 for unrelated n reasons. Psych NP was consult saw resident on 10/10/11 – no medication changes, monitor, clevening behavior. Resident #8 – This resident was person lift as of 6/3/11 to help minimize the risk of further inju CNA's involved in inappropriat transfers were counseled regard transfer & moving of resident properties assessment during investig on 6/2/11 by nursing manageme and CNA's were in-serviced regarding transfers on 6/3/11 by rehab department and nursing management. Resident expired	nedical red and hart a 4 rry. e ing rior to gation	
	address the resident use of the wheelchair wing # I and # IV in I (situation in which a pwith one or more required to a caused, or is like injury, impairment or The facility provided a Compliance on Novemborrective actions impated the Infor-compliance for F	provider's noncompliance uirements of participation ly to cause serious harm, death). a Credible Allegation of mber 8, 2011. A revisit ber 10, 2011, revealed the plemented on November 8.		11/13/11. Resident #3 – CP was updated 11/2/11 to include use of gait bel mechanical lift depending on res cooperation. Nursing staff was it serviced on updated care plan on 11/2/11 and 11/5/11 (Baylor) by mursing management. Rehab screening management. Rehab screening ability of resident to be transferred by gabelt. Resident #5's soft belt was immediately placed correctly on October 18, 2011. Nursing management assessed resident on 10/26/11 and an alarming seat belt.	ident n- een lity ait	

CENT	ERS FOR MEDICARE	AMND HUMAN SERVICES & MEDIC/ SERVICES		No. 72	Furiv	311/15/2011 APPROVED . 0938-0391
AND PLAI	N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	JLTIPLE CONSTRUCTION DING	(X3) DATE S COMPLI	URVEY
		445141	B. WING	G	1	R 10/2011
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 100	0/2011
BRADI	LEY HEALTH CARE & F	REHAB		2910 PEERLESS RD CLEVELAND, TN 37312		
(X4) ID PREFI) TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE	DUI D BE	(X5) COMPLETION DATE
{F 323	This REQUIREMENT by: Based on medical reports, observation failed to provide supresident (#15) with tharming self and other transfer for one resident sustaining a falled to use a mech resident (#3); failed to properly and use an resident (#5); failed the biohazard rooms; an personal alarm for residents reviewed. The facility's failure to address the resident wing # I and # IV in I (situation in which a put with one or more required to make the injury, impairment or the facility provided a compliance on Novem corrective actions important to the Important of the Important for Forest to the Important of the Important for Forest in the Impor	ecord review, review of facility, and interview the facility ervision to prevent one behavioral problems from pers; failed to provide a safe dent (#8) which resulted in the a right distal femur fracture; anical lift when transferring to apply a soft belt restaint appropriate transfer for a secure one of seven difailed to activate the esident (#14) of forty-nine a supervise resident #15 and a unsafe behaviors in the relaced the residents on mmediate Jeopardy provider's noncompliance uirements of participation by to cause serious harm, death). The Credible Allegation of mber 8, 2011, A revisit ber 10, 2011, revealed the plemented on November 8.	{F 323	was placed, this was care plantin-servicing of CNA's done of 10/26/11. CNA's performing inappropriate transfer and mo resident prior to nurse assessmer were counseled on 10/18/11 as serviced on 10/19/11 by nursis management an rehab departing Biohazard room key was moven near the door to the nurses desabove doorknob states "See makey." Key was removed from October 18, 2011. Resident #14 — the alarm was activated on October 18, 2011 new alarm chair pad with activations the box was placed on reful/2/11 to ensure activation. A checks are done by CNA's dur walking rounds routinely during care and a light flashes when be is needed. The CNA's are insa new alarms are placed by numanagement. Alarms placeme tracked through QA nurse and are discussed during weekly su meeting. In-servicing began or 10/28/11 and all staff were inserviced by 11/7/11 unless on vacation or leave and they will serviced on date of return to wo All agency staff will be in-serviprior to work. B. All residents have the potential adversely affected by this deficiprocess. Residents at risk are identified by incident reports, residents in the serviced of the potential adversely affected by this deficiprocess. Residents at risk are identified by incident reports, residents at risk are identified by incident reports.	ving nent nd in- ng nent ed from k. Sign use for door A aation esident alarm ing g daily attery erviced rsing nt is alarms b QA	

DEPANOV. 29. 2011 E. 9:06AMND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDIC. SERVICES

No. 7203-KINP. 3411/16/2011 FORM APPROVED OMB NO. 0938-0391

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	150	445141	B. WI			1	R 0/2011
	ROVIDER OR SUPPLIER			2	REET ADDRESS, CITY, STATE, ZIP CODE 910 PEERLESS RD CLEVELAND, TN 37312	11/1	0/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	This REQUIREMENT by: Based on medical reports, observation failed to provide sure resident (#15) with harming self and ot transfer for one resident sustaining failed to use a medical resident (#3); failed properly and use an resident (#5); failed biohazard rooms; as personal alarm for residents reviewed. The facility's failure address the resident use of the wheelchawing #1 and #1V in (situation in which a with one or more rechas caused, or is like injury, impairment or the facility provided Compliance on Novercorrective actions im 2011, removed the I Non-compliance for	record review, review of facility and interview the facility pervision to prevent one pehavioral problems from thers; failed to provide a safe dent (#8) which resulted in the aright distal femur fracture; nanical lift when transferring to apply a soft belt restaint appropriate transfer for to secure one of seven and failed to activate the esident (#14) of forty-nine to supervise resident #15 and t's unsafe behaviors in the ir placed the residents on Immediate Jeopardy provider's noncompliance quirements of participation ely to cause serious harm, redeath). a Credible Allegation of ember 8, 2011. A revisit niber 10, 2011, revealed the aplemented on November 8,	{F 3	23}	screens, admission history, and residents with restraints. Residents with behavioral problems need supervision to prevent self har negative interaction were identified by MDS assessment, behavior incident reports, and staff inter by social service staff beginning 11/4/11 & completed 11/7/11. have been reviewed and update needed and in-servicing of update completed 11/7/11 by SS staff nursing management. Resident requiring assistance with transitive was identified by nursing management per review of CP assessment on 11/7/11 – 19 restricted CP's were updated by nursing management to reflect care required/given. In-services of updates to direct care staff by management was completed 11 Residents with restraints were observed on 10/19/11 by nursing management & rehab staff regative appropriate placement and no crestraints were placed incorrect Daily observation by nurses & nursing management during car continues and in-servicing by management & rehab will continue on orientation and per occurrent Residents with alarms were chefor activation by nursing management activated. Review of alarms were chefor activation by nursing management activated. Review of alarms were	dents ling m and tified sheets, rviews ng CP's ed as lated & tts fers and sident mursing r/8/11. ng arding other cly. re nursing inue ce. ecked gement ns not	

DEPANOV. 29. 2011 E 9: 07AM ND HUMAN SERVICES No. 7203 RILP. 3511/15/2011 FURM APPROVED CENTERS FOR MEDICARE & MEDICA OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 445141 11/10/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2910 PEERLESS RD BRADLEY HEALTH CARE & REHAB CLEVELAND, TN 37312 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) {F 323} Continued From page 21 {F 323} prevent accidents. done on 11/7/11 by nursing management with no further action needed. CNA round sheets include checking of alarms. All other 6 biohazard doors were checked by This REQUIREMENT is not met as evidenced environmental service director and by: keys moved & signs placed where no Based on medical record review, review of facility key pad is in place. Residents at risk reports, observation, and interview the facility are reviewed in weekly sub OA failed to provide supervision to prevent one meeting with nursing management, resident (#15) with behavioral problems from rehab, SS staff, medical director, harming self and others; failed to provide a safe pharmacy consultant. Supervision to: transfer for one resident (#8) which resulted in the prevent behavior issues resulting in resident sustaining a right distal femur fracture; harm to self & others, prevent failed to use a mechanical lift when transferring inappropriate transfers resulting in resident (#3); failed to apply a soft belt restaint harm, using transfer properly and use an appropriate transfer for recommendations appropriate for resident (#5); failed to secure one of seven residents, applying ordered biohazard rooms; and failed to activate the appropriate restraint properly, personal alarm for resident (#14) of forty-nine securing biohazard rooms, and residents reviewed. appropriate alarms in working order & activated, will be provided by The facility's failure to supervise resident #15 and nurses, nursing staff, nursing address the resident's unsafe behaviors in the management, psych NP, therapy use of the wheelchair placed the residents on dept., social services, activities, Wing # I and # IV in Immediate Jeopardy administrator, MD/NP, medical (situation in which a provider's noncompliance director by in-servicing at monthly with one or more requirements of participation mandatory meetings as needed by has caused, or is likely to cause serious harm. occurrence. Nursing management injury, impairment or death). will do compliance rounds/ daily observation and will make referrals to The facility provided a Credible Allegation of

Compliance on November 8, 2011. A revisit

2011, removed the Immediate Jeopardy.

conducted on November 10, 2011, revealed the

corrective actions implemented on November 8.

Non-compliance for F-323 continues at a "E" level

citation (potential for more than minimal harm).

dictates.

therapy, social service dept. and

psych NP as needed. Review of

done weekly with this team &

residents identified at risk will be

medical director as resident need

DEP.Nov. 29. 2011 H 9:07AM HUMAN SERVICES No. 7203 PRIP. 36 11/15/2011 FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 445141 11/10/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **BRADLEY HEALTH CARE & REHAB** 2910 PEERLESS RD CLEVELAND, TN 37312 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5)PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) {F 323} Continued From page 21 {F 323} Supervision will be by observation. prevent accidents. assessment and by following plan of care on a daily basis by weekly meetings and quarterly assessments (MDS). Interventions and/or changes will be in place and staff notified at This REQUIREMENT is not met as evidenced that time by appropriate dept. D. Behaviors, resident to resident Based on medical record review, review of facility altercations, restraints, alarms, change reports, observation, and interview the facility in condition of resident will be failed to provide supervision to prevent one reviewed by IDT in weekly meetings resident (#15) with behavioral problems from and with daily observations by harming self and others; failed to provide a safe nurses, nursing management, therapy transfer for one resident (#8) which resulted in the staff, activity staff, dietary staff, resident sustaining a right distal femur fracture: environmental services staff, social failed to use a mechanical lift when transferring service staff, and administration. resident (#3); failed to apply a soft belt restaint QA meetings will report trends in properly and use an appropriate transfer for behaviors, bruises, unknown origin resident (#5); failed to secure one of seven incidents, and report on restraints and biohazard rooms; and failed to activate the alarms and interventions taken personal alarm for resident (#14) of forty-nine throughout the month. In-servicing residents reviewed. will occur at monthly mandatory meetings and as incidents occur. The facility's failure to supervise resident #15 and address the resident's unsafe behaviors in the use of the wheelchair placed the residents on Wing # I and # IV in Immediate Jeopardy (situation in which a provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious harm,

injury, impairment or death).

The facility provided a Credible Allegation of Compliance on November 8, 2011. A revisit conducted on November 10, 2011, revealed the corrective actions implemented on November 8, 2011, removed the Immediate Jeopardy.

Non-compliance for F-323 continues at a "E" level citation (potential for more than minimal harm).

DEP/	Nov. 29. 2011, 9:0/ ERS FOR MEDICARE	AM ND HUMAN SERVICES & MEDIC) SERVICES		N	lo. 7203 prip. 3 FORM	1 APPROVED	
STATEM	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL	JLTIPLE CONSTRUCTION DING	(X3) DATE S	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		445141	B. WIN	G	-	R	
NAME O	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP		10/2011	
	LEY HEALTH CARE & F			2910 PEERLESS RD CLEVELAND, TN 37312	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
{F 323	Continued From pa	ge 22	{F 32	3}			
	management policy and interviews with Social Worker, nurs The facility's inservice policy and procedure #15 had been dismit	complished through medical					
{F 329} \$S=D	correction to include ensure the deficient the facility's corrective reviewed and evalual Committee. 483.25(I) DRUG REC	an acceptable plan of continued monitoring to practice does not recur and re measure could be ted by the Quality Assurance	{F 329	}	4.5		
	drug when used in ex- duplicate therapy); or without adequate mo- indications for its use	regimen must be free from An unnecessary drug is any cessive dose (including for excessive duration; or nitoring; or without adequate; or in the presence of es which indicate the dose discontinued; or any easons above.					
1	resident, the facility m who have not used an given these drugs unli therapy is necessary t	o treat a specific condition umented in the clinical					

Nov. 29. 2011 9:07AM HUMAN SERVICES No. 7203 PRIP. 38 11/15/2011 FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 445141 11/10/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE BRADLEY HEALTH CARE & REHAB 2910 PEERLESS RD CLEVELAND, TN 37312 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE ID PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION DATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) {F 329} Continued From page 23 {F 329} drugs receive gradual dose reductions, and A. Resident #23 the physician ordered behavioral interventions, unless clinically 11/14/11 dose was given on September 11, 2011 contraindicated, in an effort to discontinue these for Lorazepam and on October 11, 2011 drugs. for Risperidone and continues to be given as ordered. B. All residents with med changes have the potential to be adversely affected by this deficient process. Chart checks will be completed and noted O This REQUIREMENT is not met as evidenced day by charge nurses assuring orders are noted & completed. Based on medical record review and interview C. A new protocol for chart checks was the facility failed to implement a physician's order instituted & in-serviced by nursing timely, resulting in the administration of unnecessary anti-anxiety and anti-psychotic management on how to audit with completion by 11/14/11 and during medication doses for one resident (#23) of forty-nine residents reviewed. chart audits nursing management will review for accuracy. Nursing management will review The findings included: charts for accuracy during chart Resident #23 was admitted to the facility with audits weekly, monthly and prn. They diagnoses including Alzheimer's Dementia and will use pharmacy faxes, nurses 24 hour report and lab requisitions to Aphasia. review also. Medical record review of the Minimum Data Set (MDS) dated October 4, 2011, revealed no behaviors were exhibited. Medical record review of the Physician's Communication Form dated June 20, 2011, revealed "...attempt periodic dose reduction...current dose of Lorazepam

7-13-11..."

(anti-anxiety) 0.5 mg. (milligram) ½ tab (half tablet) (0.25) BID (twice daily)...consider Lorazepam 0.5 mg. ½ (0.25 mg.) QD (every day)...Physicians Response: Will try...date

DEPA	۷۵۷. <mark>۷۶. ۷۵۱۱ ا با ۷</mark> ۲	AMIND HUMAN SERVICES			No. /20	3PRIP. 3	9 11/15/2011
CENT	ERS FOR MEDICARE	& MEDIC/ SERVICES			5030000-X	FORM	APPROVED
STATEM AND PLA	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		445141	B. WII	NG	•	R	
NAME O	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	T 710 000E	11/	10/2011
BRADI	LEY HEALTH CARE & R	REHAB		2910 PEERLESS RD			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		CLEVELAND, TN 37312			
PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	CROSS-REFERENCE	F ACTION SHOL	III D DE	(X5) COMPLETION DATE
{F 428} SS=D	Medical record revie Administration Record 2011, revealed the record control September 11, 2011 unnecessary doses Medical record revie Communication Fort pharmist, dated Sep "attempt periodic of (anti-psychotic) 1mg Risperidone 0.5mg H OK to try dose reduce Medical record revie 1, 2011, revealed the receive Risperidone 2011, until October 1 unnecessary doses of Interview with Registe 20, 2011, at 9:00 a.m. Station, confirmed the physician's orders for September 11, 2011, twenty-six unnecessar 2011 for Risperidone, unnecessary doses. 483.60(c) DRUG RECORREGULAR, ACT Of The drug regimen of each	ew of the Medication and (MAR), dated August 1, resident continued to receive a BID from July 13, 2011 until 1, resulting in twenty-six of Lorazepam 0.25mg. Ew of the Physician's m, completed by the tember 12, 2011, revealed lose reductionRisperidone (milligram) HS (nightly)try 4SPhysicians Response: stiondated 10/6/11" Ew of the MAR dated October excitondated 10/6/11" W of the MAR dated October excitondated 10/6/11" W of the MAR dated October 6, 1, 2011, resulting in five of Risperidone 1mg. Ered Nurse #1 on October 1, in Wing Two-Nurses' excility failed to follow a dose reduction until for Lorazepam, resulting in try doses, and October 11, resulting in five EIMEN REVIEW, REPORT N	{F 428	29}	JENCT		
	The pharmacist must the attending physicial	report any irregularities to n, and the director of					

CENTE	RS FOR MEDICARE	AM AND HUMAN SERVICES & MEDIC O SERVICES			No. 720	FORN	11/15/2011 APPROVED)
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		CONSTRUCTION	(X3) DATE:		Contract of the last of the la
		445141	B. WING				Ř	
NAME OF P	PROVIDER OR SUPPLIER					11/	10/2011	_
	Y HEALTH CARE & R			2910	FADDRESS, CITY, STATE, ZIP CODE PEERLESS RD :- VELAND, TN 37312			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	II D RE	(X5) COMPLETION DATE	-
	This REQUIREMEN by: Based on medical nothe facility failed to for recommendations for manner for one residents reviewed. The findings included residents reviewed. The findings included Resident #23 was according Aphasia. Medical record review (MDS) dated October resident had short an problems, and no below the communication for months and record review communication for months and recording the communication for months and steed Juliantempt periodic do	T is not met as evidenced ecord review and interview ollow pharmacy consultant or dose reductions in a timely dent (#23) of forty-nine d: Imitted to the facility with the Alzheimer's Dementia and of the Minimum Data Set of 4, 2011, revealed the d long term memory naviors were exhibited.	{F 426	B.	Resident #23 was given correct ordered by 10/11/11. Pharmacy consultant and DON reviewed protocol on 11/4/11 at monthly reviews will now be to MD/NP within 7-10 days of reviewes related to medical issue: All residents have the potential adversely affected by this defici process. Protocol has been updes on monthly reviews will be to MD/NP's within 7-10 days of recommendations every week or sooner as severity demands to be given to MD/NP. Recommendations will be processed immediately a MD/NP review. New recommendation forms time table will be implemented by 11/11/11, where monthly review be generated weekly or sooner as completed. Nursing management and pharmaconsultant will monitor for compliance on a weekly basis.	iew or ency of s. to be ent ated eview.	11/11/11	
ti d C tr	ab (half tablet) (0.25 laily)consider Loraz	mg.) BID (twice sepam 0.5 mg. ½ (0.25 mg.) sicians Response: Will re than three weeks						

DEP/N	0V. Z9. Z011-1 9:08 ERS FOR MEDICARE	AMND HUMAN SERVICES & MEDIC SERVICES		No. /2	FOR	1 11/15/2011 M APPROVED
STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUIL	ULTIPLE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		445141	B. WIN	G	1	R
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 11/	10/2011
	EY HEALTH CARE & R			2910 PEERLESS RD CLEVELAND, TN 37312		
(X4) ID PREFIX TAG	CEACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	HIDRE	(X5) COMPLETION DATE
	Communication For pharmacist, dated S "attempt periodic of (anti-psychotic) 1mg Risperidone 0.5mg I OK to try dose reduct than three weeks late Interview with Regist 20, 2011, at 9:00 a.m Station, confirmed the physician of the pharmacist dose reduction for the Risperidone. 483.60(b), (d), (e) DF LABEL/STORE DRU The facility must emparation of records of receipt a controlled drugs in surfaceurate reconciliation records are in order a controlled drugs is mare conciled. Drugs and biologicals fabeled in accordance professional principles appropriate accessory instructions, and the eapplicable. In accordance with Staticality must store all docked compartments	m completed by the september 12, 2011, revealed dose reductionRisperidone (milligram) HS (nightly)try HSPhysicians Response: etiondated 10/6/11 (more er)" sered Nurse #1 on October in, in Wing Two Nurses' is facility failed to notify the macist recommendations for e Lorazeparn and RUG RECORDS, GS & BIOLOGICALS soloy or obtain the services of it who establishes a system and disposition of all inflicient detail to enable an in; and determines that drug and that an account of all inflicient and periodically used in the facility must be with currently accepted in the facility must be with currently accepted in the facility must be and cautionary expiration date when	{F 42	8}		

DEPAN	ov. 29. 2011-L9:08A			N	. 7203 PRIP. 4	42 11/15/2011 MAPPROVED	1
STATEME		& MEDIC SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	ULTIPLE CONSTRUCTION DING	(X3) DATE S). 0938-0391 SURVEY	1
NAME OF	DDG 45-5-5-5	445141	B. WING	3	11/	∖R 10/2011	
BRADL	PROVIDER OR SUPPLIER EY HEALTH CARE & RE		s	STREET ADDRESS, CITY, STATE, ZIP O 2910 PEERLESS RD CLEVELAND, TN 37312		10/2011	
(X4) ID PREFIX TAG	(EACH DEFICIENCY)	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
-	The facility must prove permanently affixed of controlled drugs listed. Comprehensive Drug Control Act of 1976 a abuse, except when the package drug distribut quantity stored is mind be readily detected. This REQUIREMENT by: Based on observation policy, and interview, medications and food laboratory supplies in rooms, and failed to discuspiles in one of seventh of the findings included: Observation and interview, must be findings included: Observation and interview, on October 19, 2000 revealed six blue top sexpiration date of Auguresident use.	vide separately locked, compartments for storage of d in Schedule II of the Abuse Prevention and and other drugs subject to the facility uses single unit ation systems in which the imal and a missing dose can is not met as evidenced in, review of the facility the facility failed to separate and discard expired four of four medication iscard expired laboratory en biohazard rooms. View with Licensed Practical wing four medication 2011, at 10:00 a.m., pecimen tubes with an ust, 2011, available for	{F 431		medicine 19, 2011. All vere discarded cility policy t no food in cential to be deficient ons, will be nagement & gards to upplies. In- ompleted rsing complete with v week and iance. Lab f supplies checked by d. rmacy s will	11/14/11	
	(RN) #1, of the wing tw October 19, 2011, at 10	0:15 a.m., revealed 100 s with an expiration date of for resident use.					

DEP/NO CENTE	ov. 29. 2011 ₁ 9:08 RS FOR MEDICARE	AM ND HUMAN SERVICES			No. 7	203 PRIP.	43 11/15/2011 M APPROVED
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		PLE CONSTRUCTION		0. 0938-0391 SURVEY
		445141	B. WIN	IG _			R
NAME OF	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP COD	11/	10/2011
	EY HEALTH CARE & R	1999-11 0-1 1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-		29	010 PEERLESS RD LEVELAND, TN 37312	L	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AL DEFICIENCY)	HOURDE	COMPLETION DATE
Ft acaas	biohazard room on value and the secure unit medication and interest with september, 2011, at 10:15 a.m., specimen tubes with September, 2011, at 10:25 a.m., reveal medication refrigerate (milliliter) vials of Lar Acetaminophen suppression of thirty-seven 8 ounce eighteen 32 fluid oun supplement; fifteen 8 glucose control; and Observation and interescure unit medication refrigerate promethazine; ninety suppositories; one both according to the facility president use. Review of the facility president use. Review of the facility president use.	wing one, on October 19, revealed 98 blue top an expiration date of vailable for resident use. Prview with LPN #8, of the room, on October 19, 2011, led the following in the for: two, unopened, 10 ml of the insulin; one box of positories, 650 mg mcg (microgram) Forteo of ml vials Novolin R insulin; cans nephro supplement; cans nephro supplement; cans nephro supplement; cans nephro supplement; cans of boost 15 cups of pudding. Prview with LPN #6, of the on room, on October 19, revealed the following in the price of the interval of the	{F 43	31}			

CENT	ERS FOR MEDICARE	AMND HUMAN SERVICES & MEDIC > SERVICES			No	. 7203PRIIP.	M APPROVE
AND PLAN	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) Mi A. BUII		E CONSTRUCTION	(X3) DATE	0. 0938-039 SURVEY LETED
MARKEDE	PROMINED OF 1	445141	B. WIN	G			R
1	PROVIDER OR SUPPLIER EY HEALTH CARE & F	Manager and the second		291	ET ADDRESS, CITY, STATE, ZIP CO O PEERLESS RD EVELAND, TN 37312	DDE	/10/2011
PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CO. (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
	with the Director of office confirmed me with food. 483.65 INFECTION SPREAD, LINENS The facility must est Infection Control Prosafe, sanitary and coto help prevent the dof disease and infection Confrol The facility must esta Program under which (1) Investigates, continuity (2) Decides what prosabould be applied to a (3) Maintains a record actions related to infection determines that a resiprevent the spread of isolate the resident. (2) The facility must procommunicable disease from direct contact will transity.	Nursing (DON) in the DON's dications are not to be stored CONTROL, PREVENT ablish and maintain an organ designed to provide a profortable environment and evelopment and transmission in terminal program ablish an Infection Control in terminal program ablish an Infection Control in terminal program and prevents infections and prevents infections and individual resident; and do for incidents and corrective ctions. If of Infection in Control Program dent needs isolation to infection, the facility must rehibit employees with a general process or their food, if smit the disease, quire staff to wash their tresident contact for which	{F 44	B.	Resident #18 dressing charaddressed by nursing adm with treatment nurses immediately on October 1 policy reviewed. Resident #19's charge nurse counseled on 10/19/11by nursuagement regarding not meds other than po meds in room. Employees passing were instructed on proper vice water on 10/19/11 by nursuagement. All residents have the poter adversely affected by this diprocess. In-servicing was dil/14/11by nursing manageregarding dressing changes, control policy, gloves, hand & passing ice water. In-servill be ongoing. Compliance rounds by nursi management, infection control pharmacy consultant will be completed weekly & prn to compliance. Also daily obsevill be done & any deficient will be corrected immediatel	9, 2011 with se was sursing giving any dining ice water way to pass ursing ntial to be deficient done by ement infection washing, vices also ing rol nurse, ensure ervation issues	11/14/11
(e	c) Linens Personnel must handle	s, store, process and					

DEP#	v. 29. 2011 _{-L} 9:09 RS FOR MEDICARE	AM AND HUMAN SERVICES & MEDIC. SERVICES			No. 720	FUR	45 11/15/2011 M APPROVED O. 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MŲL A. BŲILD		CONSTRUCTION	(X3) DATE	
		445141	B. WING				R
NAME OF F	PROVIDER OR SUPPLIER			TREET	ADDRESS, CITY, STATE, ZIP CODE	11.	/10/2011
BRADLE	EY HEALTH CARE & R	EHAB		2910	PEERLESS RD VELAND, TN 37312		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
{F 441}		ge 30 as to prevent the spread of	{F 441		Nursing management, infection		
	This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, facility policy review, and interview, the facility failed to follow the facility's policy for Infection Control during a dressing change for one resident (#18) of forty-nine reviewed; failed to maintain infection control during a medication administration for one resident (#19); and failed to maintain infection control during ice pass on the one-hundred hall for six observed residents.				control nurse, charge nurses, pharmacy consultant, and QA nurse will monitor for infection control issues. In-servicing will be ongoing and compliance will be monitored by in-service attendance and observation.		
	The findings included Observation on Octorevealed resident #1 other residents eating Continued observation Practical Nurse (LPN resident and administ the resident's left arm returned to the medic sanitizer.						
	Medication Administra 'Wash hands and p	s policy Subcutaneous ation Procedures revealed out on glovesPrepare edication slowlyRemove					
F	Review of the facility's evealed "Objective of infection and disea	s: 1. To prevent the spread					

DEP,NO	v. 29. 2011 _H 9:09 ERS FOR MEDICARE	AMAND HUMAN SERVICES & MEDIC			No. 720	FOR	16 11/15/2011 MAPPROVED
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE COMP	
)		445141	B. WIN	IG		1 11	R
	PROVIDER OR SUPPLIER			STRI	EET ADDRESS, CITY, STATE, ZIP CODE	1 11	10/2011
	EY HEALTH CARE & R				10 PEERLESS RD LEVELAND, TN 37312		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	III D RE	(X5) COMPLETION DATE
Fr	employeesWhen to touching excretion, mucous membranes. Interview on Octobe LPN #1, in the dining to be worn when addronfirmed gloves we injection was adminited to be worn when addronfirmed gloves we injection was adminited. Resident #18 was addrong December 15, 2010, Left Lower Quadrant Fallure, Sepsis, Chrodisease, and Demer Observation on Octobrevealed treatment in #2 administering a dresident's perineal and or don gloves, and resident's perineal and or don gloves, and reestablished clean field. Continued observation area revealed two fist lower quadrant. Observation area revealed treatment nuclease at this time referrieved a cotton swas swab into the medial frevealed treatment nuclease of the facility prevealed "loosen taper excelled "loosen taper ex	to Use Gloves:When secretions, blood, body fluids, is, or non-intact skin" If 19, 2011, at 8:25 a.m., with groom, revealed gloves were ministering injections, and ere not worn when the insulin stered to the resident. Idmitted to the facility on with diagnoses including copen Abscess, Acute Renal pric Obstructive Pulmonary intia. Identity of the resident nurse #1 and treatment nurse ressing change to resident realed treatment nurse #1 led dressing from the lea, failed to wash the hands furned to the already diagnose in the left ervation of the dressing vealed treatment nurse #1 alb and inserted the cotton fistula. Further observation was #1 then used the same ted into the lateral fistula. Folicy for Dressing Changes are and remove soiled over dressing and discard	{F 44	11)			

DEPAN	ov. 29. 2011+1 9:09	AMND HUMAN SERVICES			No. 720	3PRIP /	7 11/15/2011
CENTE	ERS FOR MEDICARE	& MEDIC SERVICES			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	FURIN	APPROVED
STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION	(X3) DATE S	
		445141	B. WI	NG_			R
NAME OF	PROVIDER OR SUPPLIER	, , , , , , , , , , , , , , , , , , , ,				11/1	10/2011
BRADL	EY HEALTH CARE & R	REHAB		28	EET ADDRESS, CITY, STATE, ZIP GODE 310 PEERLESS RD LEVELAND, TN 37312		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	LIIDEC	(X5) COMPLETION DATE
{F 441}	handsCleanse the for each cleansing s contaminated to the Interview on Octobe outside the Director the DON confirmed policy and procedure Observation on Octoon Wing 1 hallway, n	wound. Use separte gauze troke. Clean from the least most contaminated area" r 19, 2011, at 10:30 a.m., of Nursing (DON) office with the facility failed to follow the for dressing changes. sber 19, 2011, at 10:00 a.m., evealed Certified Nursing.	{F 4	41}			
	Further observation reach resident's room pitcher outside the roroom), placed the ice inside each pitcher (presidents), and without between residents, re	illing ice water pitchers with arate resident rooms. revealed CNA # 3 went into , took each resident water om (two residents per scoop below the rim and ottchers already used by the ut cleaning the scoop eturned the pitchers into the out sanifizing the hands					
	pitchers had been use scoop was contamina	3, on October 19, 2011, at I hallway, confirmed the ed by residents and the ted when placed inside the r interview confirmed the I the hands between					
p	October 19, 2011, at 3 confirmed the ice scool blacing ice into the res he CNA was to sanitize	ctor of Nursing (DON), on 8:00 p.m., in the DON office, by was contaminated when dident's water pitcher and the the hands between er interview confirmed the					

DEPANOV. 29. 2011HI 9:09AMND HUMAN SERVICES

CENT	ERS FOR MEDICARE	AMND HUMAN SERVICES		No.	7203 PRIP. 4	APPROVED
STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION	(X3) DATE :). 0938-0391 SURVEY
		445141	B. WII	NG		R
NAME OF	PROVIDER OR SUPPLIER			0.000	11/-	10/2011
BRADL	EY HEALTH CARE & R	EHAB		STREET ADDRESS, CITY, STATE, ZIP CO 2910 PEERLESS RD CLEVELAND, TN 37312	DE	
(X4) ID PREFIX TAG	(CACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COL	I SHOULD BE	(X5) COMPLETION DATE
{F 441}	CNA failed to follow practice.	standard infection control	{F 44	41}	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	A facility must be ad enables it to use its refficiently to attain or practicable physical, well-being of each re This REQUIREMENT by: Based on observation facility policy review, failed to be administed an effective system winjuries of unknown or investigated, resulting origin not being thorous (#12) resident, failed to and safe use of a where social services were persident in order to preharming self and other social services were persidents reviewed where social services were persidents	ministered in a manner that resources effectively and maintain the highest mental, and psychosocial sident. T is not met as evidenced in, medical record review, and interview, the facility ared in a manner to ensure reas in place to investigate rigin were thoroughly in an injury of unknown ughly investigated for one to ensure the supervision electrain for one (#15) event the resident from rs, and failed to ensure frovided for residents (#12, thaviors for forty-nine rich placed resident #12, mediate Jeopardy (a povider's non-compliance reaches to cause serious harm, death). Credible Allegation of the rs, 2011. A revisit er 10, 2011, revealed the emented on November 8.	{F 49	11/2/11 to include use of gait mechanical lift depending on cooperation. Nursing staff w serviced on updated care plan and 11/5/11 (Baylor) by nursi management. Rehab screen of 11/2/11 reflecting ability of retransferred by gait belt. Resident #5's soft belt was implaced correctly on October II. Nursing management assessed 10/26/11 and an alarming seat placed, this was care planned servicing of CNA's done on 11 Biohazard room key was moven near the door to the nurses desabove doorknob states "See nukey." Key was removed from October 18, 2011. Resident #8 – CNA's performinappropriate transfer and moversident prior to nurse assessme counseled on 10/18/11 and insappropriate transfer and moversident prior to nurse assessme counseled on 10/18/11 and insappropriate transfer and moversident prior to nurse assessme counseled on 10/18/11 and insappropriate transfer and moversident prior to nurse assessme counseled on 10/18/11 and insappropriate transfer and moversident prior to nurse assessme counseled on 10/18/11 and insappropriate transfer and moversident prior to nurse assessme counseled on 10/18/11 and insappropriate transfer and moversident prior to nurse assessme counseled on 10/18/11 and insappropriate transfer and moversident prior to nurse assessme counseled on 10/18/11 and insappropriate transfer and moversident was inserviced by 11/1/11 unless on the serviced by 11/1/11 unles	belt or resident as in- ing ompleted esident to be omediately 8, 2011. If resident on belt was and in- 0/26/11, ed from k. Sign are for door one of the sident on the sident of the sident on the sident of the sident on the sident of the side	11/13/11
{F 490} SS=E	CNA failed to follow practice. 483.75 EFFECTIVE ADMINISTRATION/ A facility must be ad enables it to use its refficiently to attain or practicable physical, well-being of each re This REQUIREMENT by: Based on observation facility policy review, failed to be administed an effective system winjuries of unknown or investigated, resulting origin not being thorous (#12) resident, failed to and safe use of a where social services were persident in order to prefix the property of the facility provided a compliance on Novembounducted on	RESIDENT WELL-BEING ministered in a manner that resources effectively and maintain the highest mental, and psychosocial sident. T is not met as evidenced in a manner to ensure vas in place to investigate rigin were thoroughly in an injury of unknown ughly investigated for one to ensure the supervision elechair for one (#15) event the residents (#12, and failed to ensure irovided for residents (#12, and failed to ensure incovided for resident #12, and failed to ensure incovided for residents (#12, and failed to ensure incovided for en	{F 49	A. Resident #3 – CP was update 11/2/11 to include use of gain mechanical lift depending on cooperation. Nursing staff w serviced on updated care plan and 11/5/11 (Baylor) by nursimanagement. Rehab screen c 11/2/11 reflecting ability of retransferred by gait belt. Resident #5's soft belt was im placed correctly on October II. Nursing management assessed 10/26/11 and an alarming seat placed, this was care planned servicing of CNA's done on 11 Biohazard room key was moven near the door to the nurses desabove doorknob states "See nu key." Key was removed from October 18, 2011. Resident #8 – CNA's performinappropriate transfer and moveresident prior to nurse assessme counseled on 10/18/11 and in-s 10/19/11 by nursing managemerehab department. This resident person transfer as of 6/3/11 & n staff was in-serviced by rehabodate. CP updated for transfer ne Resident expired 11/13/11. Inseed on 10/28/11 and all staff serviced by 11/7/11 unless on volcave and they will be in-service of return to work. All agency st in-serviced prior to work. Resident #14 – the alarm was ac	belt or resident as in- ing ompleted esident to be omediately 8, 2011. If resident on belt was and in- 0/26/11, ed from k. Sign are for door one of the from	11/1

CENTE	RS FOR MEDICARE	AMNU HUMAN SERVICES & MEDIC D SERVICES		No	7203PRHP	W APPROVED
ISTATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION	OMB NO. 0938 (X3) DATE SURVEY COMPLETED	
NAME OF F	PROVIDER OR SUPPLIER	445141	B. W			R
	Y HEALTH CARE & R	ЕНАВ	-	STREET ADDRESS, CITY, STATE, ZIP CC 2910 PEERLESS RD	DE 11/	10/2011
(X4) ID PREFIX TAG	TEMOR DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CONTROL INFORMATION)	ID PREP TAG		CHALLE	(X5) COMPLETION DATE
to the second se	Validation of the Cre Compliance was acc record review, review observations, and int Counseling Social W administrative staff. of a completed inves unknown origin of res Assistant Director of the findings and conc nvestigations of forty unknown origin. The methods adopted to fi all injuries of unknown all responsible parties of a conclusion, and of rend the injuries. The olicies/procedures in nvestigation of injuries dopted as part of the rovided evidence of in taff. the facility provided re cluding a policy for B cility provided eviden r all staff for the adop olicy and for specific r anagement plans, The anagement plans and imprehensive care plas sidents #12, 27, and en dismissed from the	F-490 continues at a "E" lever more than minimal harm). dible Allegation of complished through medical of facility policy, erviews with the Licensed orker, nurses, and The facility provided evidence tigation of the bruising of sident #12. In addition, the Nursing (ADON) provided flusions from the four additional injuries of ADON provided the acilitate the identification of a origin, communication to a horigin, communication to a facility provided new cluding a policy for sof unknown origin abuse policy, The facility in-service education for all every policies/procedures ehavior Management. The ce of in-service education of the individual behavior management esident behavior management individual behavior the individual behavior the individual behavior the facility.	ce .		ring daily battery is erviced as rsing nent is d alarms are QA meeting. east related ed by rent w/c was This w/c is staff in- sitioning on Nursing y 2 hours on onling in w/c nfort. een added after ise on July viewed y nurse and cover. ly 25, 1. ADON 's on duty igation er action jury vior or ed, no recurred. vestigation er 1 director r 25, on tor & NP	

CENTE	RS FOR MEDICARE	AMND HUMAN SERVICES & MEDIC SERVICES		No. 72	03PRIIP	5() 11/15/201 VI APPROVEI
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDEN/SUPPLIER/CLIA IDENTIFICATION NUMBER:		DULTIPLE CONSTRUCTION LDING	(X3) DATE	0. 0938-039 SURVEY
		445141	B. WIN	NG	1	R
NAME OF F	PROVIDER OR SUPPLIER					10/2011
BRADLE	Y HEALTH CARE & R	ЕНАВ		STREET ADDRESS, CITY, STATE, ZIP CODE 2910 PEERLESS RD		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		CLEVELAND, TN 37312		
PREFIX TAG	(C VOIT DEFICIENT.Y	MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	A	COMPLETION DATE
to the state of th	Validation of the Cre Compliance was acc record review, review observations, and int Counseling Social W administrative staff. To of a completed invest unknown origin of res Assistant Director of the findings and cond nivestigations of forty. Inknown origin. The methods adopted to fall injuries of unknown all responsible parties of a conclusion, and the rend the injuries. The olicies/procedures in nivestigation of injuries dopted as part of the rovided evidence of in taff, the facility provided ne- cluding a policy for B cility provided eviden or all staff for the adop- olicy and for specific r anagement plans, The anagement plans and mprehensive care pla- sidents #12, 27, and the of facility will remain of efacility will remain of	F-490 continues at a "E" lever more than minimal harm). dible Allegation of complished through medical of facility policy, rerviews with the Licensed orker, nurses, and The facility provided evidence tigation of the bruising of sident #12. In addition, the Nursing (ADON) provided lusions from the four additional injuries of ADON provided the acilitate the identification of a origin, communication to a facility provided new cluding a policy for so funknown origin abuse policy. The facility in-service education for all sew policies/procedures ehavior Management. The ce of in-service education the individual behavior the individual behavior the individual behavior the individual behavior the coinciding ans were reviewed for 30. Resident #15 had the facility.		on 11/8/11 by DON. No further were given. State guardian was in 11/1/11. In-servicing on abuse policy, unk origin, and behavior management began on 10/28/11 and all staff we serviced by 11/7/11 unless on vacue leave and they will be in-serviced of return to work. All agency staff in-serviced prior to work. Revised policy on November 6, 2011 was combining unknown injuries/accidincidents to be included in policy. In the information was added. State notified of incident & investigation through IRS system on 11/7/11. Has had a behavior component added her Care Plan 10/28/11 by social seassistant assigned to that resident. SS director (LCSW) assessed resident. SS director (LCSW) assessed resident witten behavior management plan was formulated, and then SS director in serviced nursing staff on plan and pplan in chart on 10/28/11 and also coplan placed in Behavior Sheets bool nurses station. Resident #27 has had a behavior component added to his care plan 10/28/11 by social services assistant assigned to that resident. After social service director (LCSW) assessed resident, an individualized written behavior management plan was formulated and then social service director in-serviced nursing staff on and placed plan in chart on 10/28/11 Resident #30 has had a behavior component added to his care plan 10/28/11 by social services assistant assigned to that resident. After social service director in-serviced nursing staff on and placed plan in chart on 10/28/11 Resident #30 has had a behavior component added to his care plan 10/28/11 by social services assistant assigned to that resident. After social services assi	nown policy ere in- nation or on date ff will be d abuse dent No was n ded to ervice After ent, on laced copy of k at t al	
iev	el until it provides an	acceptable plan of		service director (LCSW) assessed		

CEN	NOV. ZY. ZVIIH Y: 10 FERS FOR MEDICARE	AMND HUMAN SERVICES & MEDIC SERVICES		No.	FUNI	5 11/15/2011 vi APPROVED
STATEN	ENT OF DEFICIENCIES IN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I	ULTIPLE CONSTRUCTION LDING	(X3) DATE COMP	0. 0938-0391 SURVEY
		445141	B. WIN	IG		R
NAME C	F PROVIDER OR SUPPLIER				11/	10/2011
BRAD	LEY HEALTH CARE & R	EHAB		STREET ADDRESS, CITY, STATE, ZIP COD 2910 PEERLESS RD	E '	
(X4) II	SUMMARY STA	TEMENT OF DEFICIENCIES	_,	CLEVELAND, TN 37312		
PRÉFI TAG	X (EACH DEFICIENCY	MUST BE PRECEDED BY FULL CO IDENTIFYING INFORMATION)	ID PREF() TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULDE	(X5) COMPLETION DATE
{F 49	Non-compliance for citation (potential for Validation of the Crecompliance was accrecord review, review observations, and in Counseling Social Wadministrative staff. of a completed investing unknown origin of reads and continuestigations of forty unknown origin. The methods adopted to all injuries of unknown all responsible parties to a conclusion, and frend the injuries. The policies/procedures in investigation of injuries adopted as part of the provided evidence of staff. The facility provided mincluding a policy for Efacility provided evidence for all staff for the adopolicy and for specific management plans, in management plans and comprehensive care presidents #12, 27, and been dismissed from the control of the provided the plans and comprehensive care presidents #12, 27, and been dismissed from the control of the provided the plans and comprehensive care presidents #12, 27, and been dismissed from the control of the provided the plans and comprehensive care presidents #12, 27, and been dismissed from the control of the provided the plans and comprehensive care presidents #12, 27, and been dismissed from the control of the provided the pr	F-490 continues at a "E" level more than minimal harm). It is a more than the continues of the facility provided evidence tigation of the bruising of sident #12. In addition, the Nursing (ADON) provided clusions from the refour additional injuries of ADON provided the facilitate the identification of an origin, communication to so investigation of the injuries the system to track and the facility provided new including a policy for so of unknown origin abuse policy, The facility in-service education for all the well of in-service education pred behavior management resident behavior management resident behavior individual behavior dithe coinciding lans were reviewed for 30. Resident #15 had the facility.		behavior management plan was formulated and then social servidirector in-serviced nursing state and placed plan in chart on 10/2 Resident #15 has had a behavior component added to his care plato/27/11 by social services assigned to that resident. After service director (LCSW) assess resident, on 10/27/11an individirector in-serviced nursing staff and placed plan in chart on 10/2 One on one was already in placed continuing until out to hospital to unrelated medical issues on 11/2 in-servicing of all staff who are vacation or on leave has been in on abuse policy, incidents of unionigin policy, and behavior manapolicy by 11/7/11, returning staff in-serviced on day of return. Agwill be in-serviced prior to start of the All residents have the potential adversely affected by this deficit process. The administrator will reach incident report and will be provestigation of unknown origin along with nursing admin, abuse coordinator (SS director), SS staff MD/NP, Dept. Directors as approand medical director. C. Each incident of unknown origin behavior issues will be reviewed on upon occurrence. Also incidents unknown origin, behavior issues, application/elimination and alarm application/elimination will be reviewedly at sub QA meetings. The administrator attends all weekly sumeetings unless outside facility and receives reports as	ice ff on plan 28/11. r an stant social ed ualized lan was ce f on plan 8/11. and or //11. All not on serviced known gement will be ency staff of shift. be nt eview art of the ncidents f, priate & laily of restraint iewed	

DEP,Nov. 29. 2011, 9:11AM,ND HUMAN SERVICES No. 7203 PRIP. 52 11/15/2011 CENTERS FOR MEDICARE & MEDI FORM APPROVED D SERVICES STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY COMPLETED A. BUILDING B. WING 445141 NAME OF PROVIDER OR SUPPLIER 11/10/2011 STREET ADDRESS, CITY, STATE, ZIP CODE BRADLEY HEALTH CARE & REHAB 2910 PEERLESS RD CLEVELAND, TN 37312 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE TAG PREFIX (X5) COMPLETION CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY (F 490) Continued From page 34 {F 490} appropriate. Education & training of staff Non-compliance for F-490 continues at a "E" level regarding abuse, unknown origin citation (potential for more than minimal harm). incidents, Behavior Management Plans will be ongoing. Administrator will Validation of the Credible Allegation of continue to be involved in in-services. Compliance was accomplished through medical Administrator or designee will read and record review, review of facility policy, review all reports concerning potential observations, and interviews with the Licensed abuse/injuries of unknown origin along Counseling Social Worker, nurses, and with the incident report and also interview administrative staff. The facility provided evidence personnel having any direct knowledge of the incident to ensure that incident does of a completed investigation of the bruising of not reoccur and this information will be unknown origin of resident #12. In addition, the included in the QA meeting for review Assistant Director of Nursing (ADON) provided and follow up. the findings and conclusions from the Administrator or designee will report investigations of forty-four additional injuries of potential abuse incidents to appropriate unknown origin. The ADON provided the state agency and also to state and local methods adopted to facilitate the identification of law enforcement agencies within the all injuries of unknown origin, communication to required 5 day reporting period allowed. all responsible parties, investigation of the injuries The board of trustee's who have the to a conclusion, and the system to track and responsibility of oversight of the facilities operation were consulted on 10/25/11, trend the injuries. The facility provided new 10/28/11, and 10/29/11 by administrator policies/procedures including a policy for and/or DON and will be consulted by the investigation of injuries of unknown origin administrator regarding potential adopted as part of the abuse policy, The facility abuse/injuries of unknown origin to provided evidence of in-service education for all provide assistance in resolving these issues satisfactorily. In addition the The facility provided new policies/procedures county commissioners who oversee the including a policy for Behavior Management. The board of trustee's will be consulted as facility provided evidence of in-service education necessary along with the county mayor of Bradley County to maintain an accident for all staff for the adopted behavior management and abuse free environment in the facility. policy and for specific resident behavior management plans, The individual behavior management plans and the coinciding comprehensive care plans were reviewed for residents #12, 27, and 30. Resident #15 had

been dismissed from the facility.

The facility will remain out of compliance at an "E" level until it provides an acceptable plan of

	DEP'N 0	14. Z9. Z011 H 9:11	AMAND HUMAN SERVICES			No. 72	03 PRIP.	53 11/15/20	٧4
ı	CENTE	KS FOR MEDICARE	& MEDI D SERVICES			1. 2	FO	RM APPROV	/FI
1	STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	0.00.00			OMB	NO. 0938-03	39
I	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SU		
	- Production of Automatical Control		A. BUIL	DING		CON	MPLETED		
l			445141	B. WIN	-		V	R	
r	NAME OF	PROVIDER OR SUPPLIER	445141				1 4	1/10/2011	
					STRE	ET ADDRESS, CITY, STATE, ZIP CODE		1110/2011	
ı	BRADLE	EY HEALTH CARE & R	REHAB		29	10 PEERLESS RD			
H	7/ A / B			- 1		EVELAND, TN 37312			
	(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID		PROVIDER'S PLAN OF CORRECT	OTION:		
	TAG	REGULATORY OR LE	SC IDENTIFYING INFORMATION)	PREFIX		CENCIT CORRECTIVE ACTION SUR		COMPLETIC	A.
_				TAG		OROSS-REFERENCED TO THE APP	ROPRIATE	DATE	714
				+		DEFICIENCY)			
	{F 490}	Continued From page	ge 35						
		correction to include	continued monitoring to	{F 49	0}			1	
		ensure the deficient	practice does not recur and						
		the facility's correction	ve measure could be						
		reviewed and evalua	ated by the Quality Assurance						
		Committee.							
	{F 497}		AIDE PERFORM	/E 405	,				
	SS=E	REVIEW-12 HR/YR	INSERVICE	{F 497	3			1	
	1	TI. 6						1	
	1	The facility must con	nplete a performance review						
		or every fluise alide a	II IPAST ONCO OVORY 12						
		monus, and must br	OVIDA FROUIAF in contino		I A	 In-servicing began on October 	25, 2011	11/20/11	- 1
		education pased on t	the hutcome of those			for those 27 CNA's who have	not		1
		reviews. The in-serv	ice training must be			received 12 hours of in-service			- [
		nurse sides but mus	ne continuing competence of			education in the past year. In-se	rvicing		
		per year, address are	t be no less than 12 hours			was done by nursing manageme social service staff, environmen	nt,		
		determined in nurse	aides' performance reviews			service staff and rehab staff. Ir	tai		1
	1 1	and may address the	SDECIAL ROOMS of ropids			servicing is ongoing and comp	(- 1:		-
	1.5	as actemmed by the	ISCUITY Staff: and for nurse			will be met on November 20, 2	Nance N11 for	1	1
	1.5	MAGO MICHIGINA SOLVIC	: PS 10 individuals with		İ	all CNA's,	011 101		1
	1	ognitive impairments	also address the care of		B.	All CNA's have the potential to	not	1	1
	ı	he cognitively impaire	ed.			have requirements met by this			1
	1					deficient process. A new form y	vas	1	1
	1	his DEOLUBERAN				developed to track CNA in-servi	ices		ļ
	h	INS KEMOIKEMENT	is not met as evidenced			on 10/27/11 and CNA evaluation	ា \$		
	71 533		Ima o _ f _ f :		-	will be held until requirement m	et.		1
	ir	terview, the facility for	Imentation review and		С.	In-services will be logged onto n	iew	V	1
	0	f inservice education	ailed to provide twelve hours per year for twenty seven,			form at least weekly and CNA's be notified of in-service	WIII	1	1
	0	i one numbered twenty	Certified Nurse Assistante			meetings/labs being conducted.		1	1
	(0	CNA) currently emplo	ved.			Nursing management will review	, in		1
			,			service hours monthly to ensure	III-		
	T	he findings included:	1			compliance.			
				1	D.	Timely documentation of in-serv	ice		
	R	eview of Facility docu	mentation from June 2010			attendance and monthly review o	fin-		
		July 2011 revealed a	list of the current employed			service log book will be complete	ed by		
	1 6 3 1	WAS SOM the SAME !-		10					

CNAs, and the total in-service hours during the

time frame. Further review revealed

nursing management.

DEP/	Nov. 29. 2011-1 9:11 ERS FOR MEDICARE	AMND HUMAN SERVICES & MEDIC SERVICES			No. 720)3 PRIP.	54 11/15/20 M APPROVE	111 FD
STATEME	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE	O. 0938-03	91
		445141	B. WIN				R	
NAME OF	PROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE	111	/10/2011	
BRADI	EY HEALTH CARE & F	REHAB		29	10 PEERLESS RD LEVELAND, TN 37312			
(X4) ID PREFIX TAG	(CACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULDE	(X5) COMPLETION DATE	N
	twenty-seven of the listed did not have to required in-service of Interview with the Astronomy (ADON) on October the Director of Nursithe facility failed to din-service hours in Junsure if all the CNA education. The ADO quite some time" who determining the hour 483.75(I)(1) RES RECORDS-COMPLILE The facility must main resident in accordance standards and practical accurately documents systematically organism. The clinical record me information to identify resident's assessment services provided; the preadmission screening and progress notes. This REQUIREMENT by: Based on medical record for one (#20) of the facility failed to main record failed to main record failed failed to main failed failed to main failed	one hundred twenty CNAs he twelve hours of the aducation. ssistant Director of Nursing 24, 2011, at 11:30 a.m., in ing (DON) office, confirmed alculate the total number of uly 2011 and the ADON was as had the required in-service DN stated "had not done for en interviewed about its of the CNAs. ETE/ACCURATE/ACCESSIB intain clinical records on each be with accepted professional best hat are complete; ed; readily accessible; and its contain sufficient the resident; a record of the its; the plan of care and its results of any ing conducted by the State; is not met as evidenced ford review and interview, intain an accurate medical	{F 514	(i)	Resident #20 The DNR sticker a front of the chart was immediately removed. All residents have the potential to adversely affected by this deficie process. In-servicing by nursing administration of nurses and SS Director was completed by 11/7/1 and will be ongoing regarding any time a POST is completed or updatine a process and the person updating this form is responsible for applying or remove DNR sticker. All charts were reviewed by nursing mangement 11/7/11 with all charts being accurate.	o be ent 11 y ated /ing rate, kl	11/11/11	
	The findings included:							

DEP/	lov. 29. 2011 _→ 9:11	AMND HUMAN SERVICES		No.	7203 PRIP. 5	5 11/15/201
CENT	ERS FOR MEDICARE	& MEDI D SERVICES			FOR	M APPROVE
STATEME	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI	LTIPLE CONSTRUCTION	(X3) DATE COMPI	<u>0. 0938-039</u> SURVEY
		445141	B. WING		1	R
NAME OF	PROVIDER OR SUPPLIER					10/2011
BRADI	EY HEALTH CARE & F		S	TREET ADDRESS, CITY, STATE, ZIP CO 2910 PEERLESS RD CLEVELAND, TN 37312	DDE	
(X4) ID PREFIX TAG	CACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULDE	(X5) COMPLETION DATE
{F 514	Continued From page	ge 37	{F 514	}		
	Bipolar Disorder, Disorder Disorder Pulmoni Medical record revieu Order for Scope of T	w of a POST (Physicians reatment) dated and signed		D. Accuracy of chart stickers monitored by nursing mans with monthly and pra chart DON will receive notificat POST is taken to MD, and be reviewed at that time as accuracy.	agement audits. ion when chart will	
	resuscitate). Intervie Nursing (DON), in the 19, 2011, at 3:00 p.m was to be a full code inaccurate. 483.75(o)(1) QAA COMMITTEE-MEMB QUARTERLY/PLANS A facility must mainta assurance committee nursing services; a phracility; and at least 3 facility's staff. The quality assessme committee meets at lessues with respect to and assurance activities.	in a quality assessment and consisting of the director of sysician designated by the other members of the other members of the and assurance ast quarterly to identify which quality assessment	{F 520}	A. Resident #3 – CP was updated 11/2/11 to include use of gait to mechanical lift depending on recooperation. Nursing staff was serviced on updated care plan of and 11/5/11 (Baylor) by nursing management. Rehab screen con 11/2/11 reflecting ability of restransferred by gait belt. Resident #5's soft belt was implaced correctly on October 18, Nursing management assessed 10/26/11 and an alarming seat to placed, this was care planned ar servicing of CNA's done on 10/10. Biohazard room key was moved	pelt or esident sin- on 11/2/11 g mpleted ident to be nediately 2011. resident on pelt was ad in- /26/11.	11/13/11

action to correct identified quality deficiencies.

A State or the Secretary may not require disclosure of the records of such committee

near the door to the nurses desk. Sign

above doorknob states "See nurse for key." Key was removed from door October 18, 2011.

Resident #8 - CNA's performing

DEP#N	ov. 29. 2011 ₁₁ 9:12 ERS FOR MEDICARE	AMND HUMAN SERVICES & MEDIC SERVICES		No. 72	FUKIN	56 11/15/2011 A APPROVED
STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL	ULTIPLE CONSTRUCTION DING	(X3) DATE S). 0938-0391 SURVEY ETED
		445141	B. WIN	G	1 110	R
NAME OF	PROVIDER OR SUPPLIER		T.	STREET ADDRESS, CITY, STATE, ZIP CODE	1 111	10/2011
BRADL	EY HEALTH CARE & R			2910 PEERLESS RD CLEVELAND, TN 37312		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE	Olu D RE	(X5) COMPLETION DATE
	except insofar as sucompliance of such requirements of this Good faith attempts and correct quality of a basis for sanctions. This REQUIREMEN by: Based on review of Committee meeting Reports; reports filed bruising; and resident observation; and interesure the Quality Asidentified potential arimplemented a plant concern. The facility's failure to by reviewing and devaggregate to assist in plans (for individual repopulations of resider Wing I and IV in Immership I and IV in Imme	committee with the section. by the committee to identify leficiencies will not be used as is. T is not met as evidenced the Quality Assurance minutes; Weekly Skin of for residents' skin tears and at to resident altercations; erview, the facility failed to essurance Committee eas of concern and to address the areas of concern and to address the areas of concern and to address residents' safety eloping data in the formulating improvement esidents and for specific ents) placed residents on ediate Jeopardy (situation in accompliance with one or in participation has caused, or ous harm, injury, impairment of the second of the s	{F 52	inappropriate transfer and movin	t were viced on and was a 4 rsing that ded. rvicing be ination or on date d prior vated on hair pad placed ration. during ailly ry is d as sms are neeting, elated v/c was w/c is nation on in w/c dided	

CENTE	RS FOR MEDICARE	AMND HUMAN SERVICES & MEDI() SERVICES		No. 720	FUR	57 11/15/2011 M APPROVED)
STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL	ULTIPLE CONSTRUCTION LDING	(X3) DATE	IO. 0938-0391 E SURVEY PLETED	1
NAME OF PROVIDER OR SUPPLIER		B. WIN	IG	1 11	R 1/10/2011		
BRADLE	EY HEALTH CARE & R			STREET ADDRESS, CITY, STATE, ZIP CODE 2910 PEERLESS RD CLEVELAND, TN 37312	<u> </u>	710/2011	The state of the s
(X4) ID PREFIX TAG	(CACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		HDDE	COMPLETION DATE	The second second second
	citation (potential for Validation of the Cre Compliance was accrecord review, review observations, and in Counseling Social Vadministrative staff, Nursing provided the facilitate the identific unknown origin, comparties, investigation conclusion, and the injuries. The facility will remain level until it provides correction to include ensure the deficient of the facility's corrective the facility's corrective corrective was accompanied to the contract of the contract of the contract of the contract of the corrective corrective was accomplished to the contract of the	edible Allegation of complished through medical w of facility policy, terviews with the Licensed Vorker, nurses, and The Assistant Director of e methods adopted to ation of all injuries of munication to all responsible.	{F 52	ADON reviewed account on July 2 2011. Reopened investigation 10/28/11. re-interviewed nurses and CNA's a during initial discovery. Investigat was completed 11/1/11. No other was required. No intentional injurt occurred based on resident behavior reaction to others were unchanged, further incident of this type has rectabuse coordinator reviewed all documentation on 11/1/11 of investand no abuse was substantiated per clinical assessment. The medical divas notified by DON on October 2 2011. NP was notified by DON on October 28, 2011. Medical director were notified of investigation compon 11/8/11 by DON. No further on were given. State guardian was not 11/1/11. In-servicing on abuse policy, unknownigin, and behavior management pegan on 10/28/11 and all staff were serviced by 11/7/11 unless on vacatal leave and they will be in-serviced of return to work. All agency staff in-serviced prior to work. Revised policy on November 6, 2011 was combining unknown injuries/accide incidents to be included in policy. In new information was added. State unotified of incident & investigation through IRS system on 11/7/11. Has had a behavior component addeder Care Plan 10/28/11 by social serassistant assigned to that resident. A SS director (LCSW) assessed reside 10/28/11 an individualized written behavior management plan was formulated, and then SS director in-	ADON on duty tion action y or or no curred. director 5, or & NP oletion ders tified own solicy e in- tion or nn date will be abuse ent No was ed to rvice After ent, on		

DEPAN	ov. 29. 2011# 9:12	AMND HUMAN SERVICES		N	lo. 7203 Kirp	5877/15/2017
		& MEDIC SERVICES			OMB NO	PPROVED D. 0938-0391
STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDE-VSUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	LTIPLE CONSTRUCTION DING	(X3) DATE : COMPL	SURVEY
*		445141	B. WING	i	111	R
NAME OF F	PROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP C		10/2011
BRADLE	EY HEALTH CARE & F			2910 PEERLESS RD CLEVELAND, TN 37312		
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(XE) COMPLETION DATE
{F 520}	citation (potential for Validation of the Cre Compliance was accrecord review, review observations, and in Counseling Social Vadministrative staff. Nursing provided the facilitate the identification unknown origin, comparties, investigation conclusion, and the injuries. The facility will remail level until it provides correction to include ensure the deficient the facility's corrective correction to include the facility's correction to include the facility is correction.	edible Allegation of ecomplished through medical work facility policy, nterviews with the Licensed Vorker, nurses, and The Assistant Director of e methods adopted to cation of all injuries of nmunication to all responsible	{F 520	serviced nursing staff on plan in chart on 10/28/11 plan placed in Behavior Station. Resident #27 has had a becomponent added to his catorice director (LCSW) a resident, an individualized behavior management plan formulated and then social director in-serviced nursing and placed plan in chart on Resident #30 has had a becomponent added to his catorice director (LCSW) as resident, an individualized behavior management plan formulated and then social director in-serviced nursing and placed plan in chart on Resident #30 has had a becomponent added to his catorice director (LCSW) as resident, an individualized behavior management plan formulated and then social director in-serviced nursing and placed plan in chart on Resident #15 has had a behavior management formulated and then social service director (LCSW) as resident, on 10/27/11 an indivited behavior management formulated and then social sident witten behavior management formulated and then social sident on 10/27/11 in indivited behavior management formulated and then social sident on one was already in prontinuing until out to hospiun lated medical issues on in-servicing of all staff who vacation or on leave has bee on abuse policy, incidents of origin policy, and behavior to origin policy, and behavior to origin policy, and behavior to the service or the service or origin policy, and behavior to origin policy.	and also copy of heets book at shavior are plan is assistant After social assessed at written in was a service in a sassistant After social assessed written in a sassistant After social assessed written in a sassistant After social assessed written in a was service in a sassistant after social assessed in a sassistant after social and a sassistant after social assessed in a sassistant and a sassi	

CENT	ov. 29. 201111 9:12	AMNU HUMAN SERVICES		No.	7203 "FP.	59,PPROVED
STATEME	NT OF DEFICIENCIES	(X1) PROVIL JSUPPLIER/CLIA			OMB NO	D. 0938-0391
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILD	TIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED		
	445141		B. WING			R
NAME OF	PROVIDER OR SUPPLIER			TREET ARREST DISTANCE	11/	10/2011
BRADL	EY HEALTH CARE & F	REHAB	3	TREET ADDRESS, CITY, STATE, ZIP COD 2910 PEERLESS RD CLEVELAND, TN 37312	Ε	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOLII D BE	(X5) COMPLETION DATE
{F 520}	citation (potential for Validation of the Cre Compliance was ac record review, review observations, and in Counseling Social Vadministrative staff. Nursing provided the facilitate the identification unknown origin, comparties, investigation conclusion, and the injuries. The facility will remail level until it provides correction to include ensure the deficient the facility's correctivities.	r more than minimal harm). edible Allegation of complished through medical w of facility policy, aterviews with the Licensed Vorker, nurses, and The Assistant Director of emethods adopted to eation of all injuries of all munication to all responsible.	{F 520		Agency staff rt of shift. I to be cient from orts by o QA or service ven to QA findings e of need I are ng and re incident as restraint es, ittee o identify lace s, tercation ease these mine mrse will fy utor	

	v. 29. 2011 ¹⁸ 9:13	AMND HUMAN SERVICES & MEDIC SERVICES			No. 720		PPROVED .0938-0391			
STATEMENT OF DEFICIENCIES (X1) PROVIDENSUPPLIER/CLIA IDENTIFICATION NUMBER;				(X2) MULTIPLE CONSTRUCTION (X3) DATE COMP			URVEY			
445141			B. WII	NG_		1	R 0/2011			
NAME OF PROVIDER OR SUPPLIER BRADLEY HEALTH CARE & REHAB					STREET ADDRESS, CITY, STATE, ZIP CODE 2910 PEERLESS RD					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	-ix	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO GROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X6) COMPLETION DATE			
{F 520}	citation (potential for Validation of the Cru Compliance was accredited for the Cru Compliance was accredited for the Counseling Social Validations of the Counseling Social Validation of the facilitate the identification of the injuries. The facility will remain the facility will remain the correction to include ensure the deficient the facility's correction to the correction to the correction to the correction to the correction to correction to correction the facility's correction to correct the correction that t	edible Allegation of ecomplished through medical ew of facility policy, nterviews with the Licensed Worker, nurses, and The Assistant Director of e methods adopted to cation of all injuries of mmunication to all responsible	· {F 5	520}	D. Sub QA meetings will be held we the QA report will be discussed in monthly QA meeting with potent of improvement & plans impleme Sub QA meetings are attended by therapy, activities, pharmacy con SS staff, administrator, and medical director.	n ial areas ented. nursing, sultant,	•			